American Academy
of Cosmetic Surgery

beyond skin deep

27TH ANNUAL SCIENTIFIC MEETING

JANUARY 12-16, 2011

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PHOENIX, ARIZONA

WORLD CONGRESS ON LIPOSUCTION SURGERY

OCTOBER 1-3, 2010
PARK HYATT WASHINGTON DC
WASHINGTON, DC

PROGRAM CHAIRS
ROBERT A. SHUMWAY, MD
MARCO A. PELOSI II, MD
GREGORY C. ROCHE, DO

CALL FOR ABSTRACTS AND REGISTRATION AT
WWW.COSMETICSURGERY.ORG

AACS 26TH ANNUAL SCIENTIFIC MEETING FINAL PROGRAM

FINAL PROGRAM

American Academy
of Cosmetic Surgery

ABSTRACT TO IMPACT

26TH ANNUAL SCIENTIFIC MEETING

January 28-31, 2010
Rosen Shingle Creek Resort
Orlando, Florida

Program Chairs:
Mark Berman, MD
H. George Brennan, MD
Faisal A. Quereshy, MD, DDS

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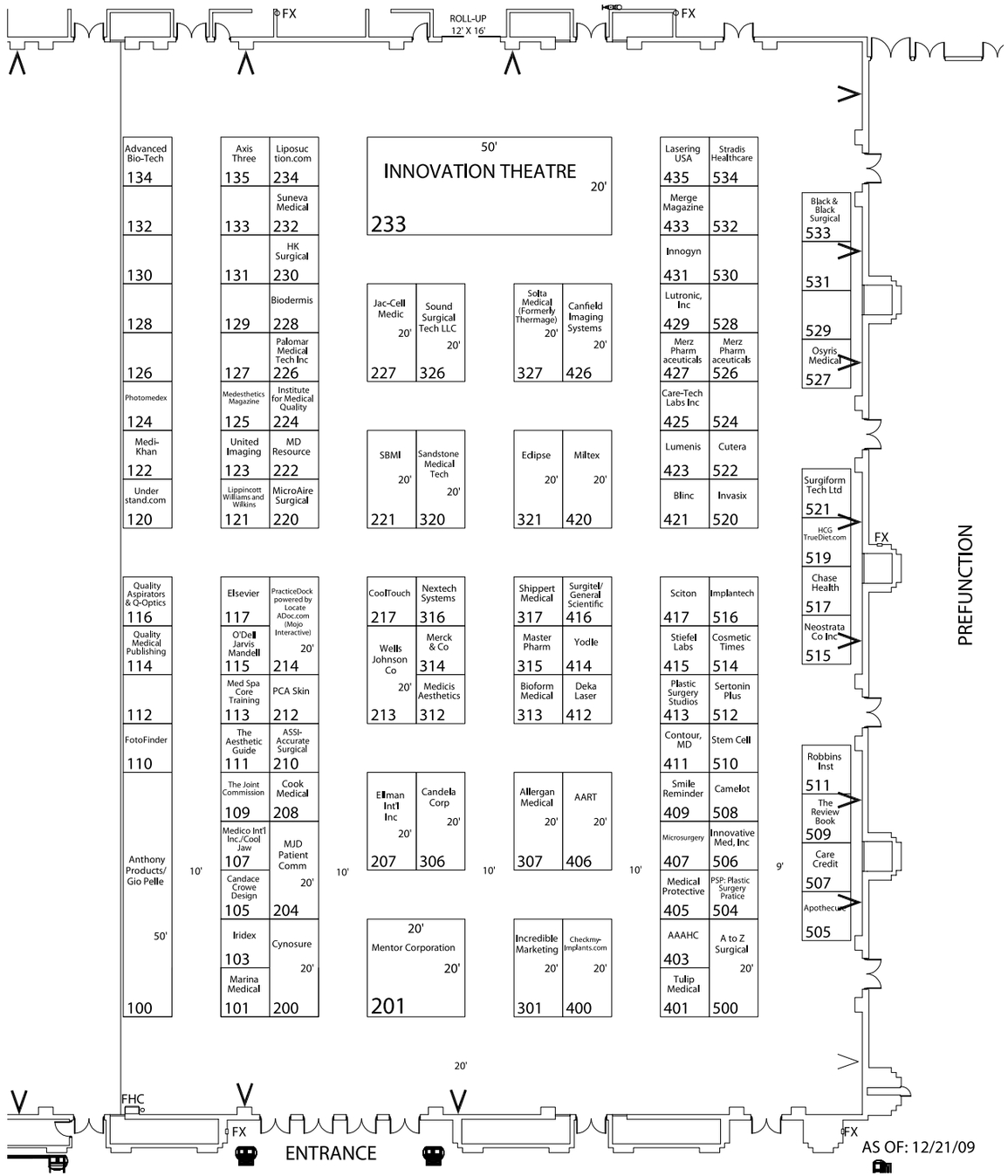

THE AMERICAN ACADEMY OF COSMETIC SURGERY | 26TH ANNUAL SCIENTIFIC MEETING

January 28-31, 2010 • Rosen Shingle Creek Resort • Orlando, Florida

NAME: _____

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GENERAL INFORMATION

AACS MEETING REGISTRATION

Location: Gatlin 1 Registration

Hours:

Tuesday, January 26	4:00 pm – 7:00 pm
Wednesday, January 27	7:00 am – 8:00 pm
Thursday, January 28	6:30 am – 4:00 pm
Friday, January 29	6:30 am – 4:00 pm
Saturday, January 30	7:00 am – 12:00 pm
Sunday, January 31	7:00 am – 12:00 pm

EXHIBITION HOURS

Location: Gatlin AB Ballroom

Hours:

Thursday, January 28	8:30 am – 6:30 pm
(Welcome Reception)	*5:30 pm – 6:30 pm*
Friday, January 29	8:30 am – 4:00 pm
Saturday, January 30	8:30 am – 12:00 pm

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

General Sessions: All general sessions are located in the Gatlin C Ballroom unless otherwise indicated.

SPEAKER READY ROOM

Location: Suwannee 11

Hours:

Wednesday, January 27	7:00 am – 6:00 pm
Thursday, January 28	7:00 am – 6:00 pm
Friday, January 29	7:00 am – 6:00 pm
Saturday, January 30	7:00 am – 5:00 pm
Sunday, January 31	7:00 am – 12:00 pm

CME Hours and Session Evaluations must be submitted at the Cyber Café located in the Gatlin Foyer.

Please complete hours and evaluations after each session attended.

TUESDAY, JANUARY 26, 2010

SCHEDULE-AT-A-GLANCE

4:00 pm – 7:00 pm	**Registration Open**
7:30 am – 8:00 am	**Continental Breakfast**
8:00 am – 5:30 pm	**International Society of Cosmetogynecology Workshop**
11:00 am – 11:15 am	**Coffee Break**
12:00 pm – 1:00 pm	**Lunch Break**
3:00 pm – 3:15 pm	**Coffee Break**
5:30 pm	**Workshop Adjourns**

TUESDAY, JANUARY 26, 2010

International Society of Cosmetogynecology Workshop
Presented by the American Academy of Cosmetic Surgery
Program Chairman: Marco A. Pelosi II, MD

Location: Gatlin E1

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

8:05 am **History of Cosmetic Vaginal Surgery and Where We Go From Here**
DAVID L. MATLOCK, MD

The best ideas are born of necessity. Nobody can say which unexpected inventions may arise from such ideas and which markets they may build. The same can be said about the history of cosmetic vaginal surgery. It was born out of the necessity to think outside the box to develop and integrate aesthetic and gynecologic techniques that were safe, effective and reproducible to meet the request of women regarding their concerns of vulvo-vaginal aesthetics. My journey started fourteen years ago when no one heard or much less cared about such things. But in this era of mass communication and media interest of the subject because "sex sells" it helped to grow and popularize the procedures which resulted in direct to consumer marketing thereby creating a patient market requesting the procedures and a surgeon market wanting training to perform the procedures. As a result the specialty is national and international and within our own organization we have about 200 surgeons (gynecologists, plastic surgeons and urologists) trained in over twenty-five countries. As to where we go from here: We must continue to romance the media which served our cause well to popularize and mainstream the procedures; but most importantly we must publish to further legitimize the specialty.

8:25 am **Female Cosmetic Genital Surgery: Ethical Considerations, Training Guidelines, Definitions and Nomenclature**
MICHAEL P. GOODMAN, MD

This presentation will review "FGPS 101", discussing:

1. What should this surgical sub-specialty be called, and why: "Female Genital Plastic Surgery (FGPS)," "Female Cosmetic Genital Surgery (FCGS)," "Vulvovaginal Aesthetics (VVA)," or "Vulvo-Vaginal Reconstruction?"

2. What should each individual operative procedure be named, and why: Labial Reduction, Labiaplasty, Designer Laser Labiaplasty? Clitoroplasty, Clitorrhaphy, Clitoral Hood Reduction Hymenoplasty, Hymenorrhaphy, Hymenal Reconstruction, Revirgination, Vaginal Rejuvenation, Vaginoplasty, Perineoplasty, Perineorrhaphy, Vaginal Reduction, Vaginal Tightening?

3. Who should be performing these procedures, and what, if any, minimal training requirements? Proctoring?

4. What are the basic medical ethical considerations and how do they specifically apply to genital plastic surgery? Specifically, the basic tenets of Patient Autonomy, Nonmalficence, Beneficence, Justice, and Veracity will be discussed.

5. What guidelines should be in place in the individual practice for the protection of the patient?

6. How does one stay as close as possible to the basic surgical dictum: "Operate on the right patient for the right reasons – and in the right way".

8:45 am **The Range of Cosmetic Vaginal Surgery**
MARCO A. PELOSI III, MD

A comprehensive review of all current available vaginal cosmetic procedures will be presented.

9:15 am **Should OB/GYN's offer Aesthetic Vaginal Procedures?**
ROBERT JASON, MD

The rational to incorporate aesthetic vaginal procedures to a traditional OB/GYN practice will be presented.

9:35 am **The Chilean Experience with Cosmetic Vaginal Surgery**
IVANHOE ORTEGA, MD AND
ARTURO HENRIQUEZ, MD

The authors experience with cosmetic gynecological surgery and general cosmetic procedures in a Chilean private practice setting will be presented.

9:45 am **The Initial Brazilian Experience with Cosmetic Vaginal Surgery**
JOAO BRITO, MD

The author's experience with cosmetic gynecological surgery and general cosmetic procedures in a Brazilian private practice setting will be presented.

9:55 am **The Dominican Republic Experience with Cosmetic Vaginal Surgery**
GABRIEL DE PENA, MD

The author's experience with cosmetic gynecological surgery and general cosmetic procedures in a Dominican Republic private practice setting will be presented.

10:05 am **The Greek Experience with Cosmetic Vaginal Surgery**
ALEXANDROS BADER, MD

The author's experience with cosmetic gynecological surgery and general cosmetic procedures in a Greek private practice setting will be presented.

10:15 am **The New York Experience with Cosmetogynecology**
KEVIN JOVANOVIC, MD

A two-physician group in Manhattan, NY experience with the addition of a Cosmetogynecology practice starting in 2005. The addition has broadened the appeal of the practice to medical and cosmetic patients. This increased significantly both patient visits and procedures for both medical and cosmetic services. The review will discuss how the transition was achieved over 2 years and strategies for addition of cosmetic procedures to a medical insurance practice. The addition of a cosmetic practice to a medical ob/gyn practice has been a considerable success for both practices.

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10:25 am **The Great Controversy: Does Vaginal Tightening Enhance Sexual Gratification?**
ROBERT MOORE, MD

A comprehensive review on the subject will be presented.

11:00 – 11:15 am **Coffee Break**

11:15 am **Master Lecture: Combined Breast Implant and Mastopexy**
ANGELO CUZALINA, MD, DDS
Recipient of the 2010 International Society of Cosmetogynecology Award for Outstanding Contributions to Cosmetic Surgery

Information not available at press time.

11:45 am **The Need for Pre-Operative Screening for Sexual Dysfunction Prior to Vaginal Tightening Procedures**
MICHAEL P. GOODMAN, MD

This presentation will speak to the following:

1. What, exactly, do we mean by "Vaginal Tightening Procedures?" Define exactly Vaginoplasty and Perineoplasty ("Vaginal Rejuvenation"), and what these procedures are designed to accomplish.

2. Why do women choose these procedures? Patient issues including lack of genital stimulation (male and female), sexual pleasure, cosmetic and aging will be discussed.

3. Why are we concerned? What's the problem here? The surgical and psychosexual pitfalls? Concerns related to the individual patient, and to public perception in general will be discussed.

4. How can we screen our patients for sexual and body image disorders and dysfunction? The basic tools, both "uncovering" questions and testing instruments, along with when and to whom to refer, will be discussed. The dictum, "Measure Twice, Cut Once" does not apply only to technique, but to emotional and psychosexual screening as well.

5. When to bring in the sexual partner. How to get adequate training to screen for sexual dysfunction:

   a) Recommend specific journals and textbooks

   b) Recommend specific organizations, meetings, courses and seminars; these are just as important as workshops in technique.

12:00 – 1:00 pm **Lunch**

1:00 pm **Colpoperineoplasty in Women with a Sensation of a Wide Vagina: The Rationale for Cosmetic Vaginal Surgery**
JACK PARDO, MD

The author's successful extensive experience on cosmetic vaginal surgery confirmed the efficacy and safety of these types of surgeries.

1:08 pm **Volume Increase of the Mons Pubis, Labia Majora, and Vaginal Canal: A New Technique**
RAMON ESPINAL, MD

The author's minimally invasive technique to achieve volumetric enhancement of the mons pubis, labia majora, and vaginal canal will be presented.

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1:15 pm **Labia Minora, Labiaplasty & Clitoral Hood Reduction Techniques**
ADAM OSTRZENSKI, MD

PART 1 BACKGROUND: Labia minora labioplasty is one of the external genitalia rejuvenation procedures. This author defines external genitalia rejuvenation as a transformation of the external genitalia to youthful appearance. External genitalia rejuvenation can be offered for each organ separately (the mons pubis, clitoral hoodoplasty, clitoroplasty, labia minora labioplasty, hymenoplasty, vaginal introitus reconstruction and labia majora labioplasty) or as one package including all external genitalia organs.

OBJECTIVE: To present pros and cons of existing surgical techniques for labia minora labioplasty.

STUDY DESIGN:

1. To review cosmetic surgery publications between June 1990 and June 2009.

2. To establish pros and cons of these surgical procedures for clinical application. Study was conducted to use computerized data banks, manual research and gather anecdotal surgical techniques related to labia minora labioplasty.

RESULTS: The following published surgical techniques in peer review journals for labia minora labioplasty were identified:

1. V-plasty technique (GJ Alter. 1998)

2. Simple V-plasty technique with surgical clamps (R Rouzier et al., 2000)

3. Deep de-epithelialization technique (CH Youn et al., 2000)

4. Nymphectomy with 90-degree Z-plasty (F Giraldo et al., 2004)

5. Laser labioplasty of labia minora (J. Pardo, et al., 2006)

6. Inferior wedge resection and superior pedicle flap reconstruction (AM Munhoz et al., 2006)

The following unpublished surgical techniques were identified:

1. Total or partial labia minora amputation (anecdotal)

2. Labia minora fenestration (Ostrzenski, pending publication)

3. Modification inferior wedge resection and superior pedicle flap reconstruction (Ostrzenski, pending publication)

4. C02 laser application for deformity of labia minora (Ostrzenski, pending publication)

CONCLUSIONS:

1. There is no one-size-fit-all technique for labia minora labioplasty that will provide optimal esthetic surgical outcome.

2. Proper selection of the surgical technique or combination of existing methods will provide optimal surgical results of labia minora labioplasty.

3. Significant cosmetic improvement of labia minora labioplasty is accomplished, when clitoral hoodoplasty and/or labia majora labioplasty are performed concomitantly (vertical elliptical excision or Ostrzenski's Colles' fascia reconstruction or Ostrzenski's unprocessed fat transfer technique for labia majora labioplasty).

PART 2 BACKGROUND: Since a cosmetic surgery for the prepuce of the clitoris falls into three categories: clitoral hood reduction (the most common performed type of operation); clitoral prepuce reconstruction; and reversed clitoral hood reduction, it is this author's suggestion to use a more universal nomenclature such as clitoral hoodoplasty. "Clitoral hoodoplasty" taxonomy encompasses all surgical, cosmetic categories for the prepuce of the clitoris. Therefore, the use of clitoral hoodoplasty provides more general expression.

OBJECTIVES:

1. To present cosmetic indications for clitoral hoodoplasty (for clitoral hood reduction, clitoral hood reconstruction, and reversed clitoral hood reduction).

2. To describe cosmetic surgical techniques for clitoral hood reduction, clitoral prepuce reconstruction, and reversed clitoral hood reduction.

STUDY DESIGN: To extrapolate surgical results in all 3 categories of cosmetic clitoral hoodoplasty from the author's practice data bank.

RESULTS: Ostrzenski's techniques for clitoral hood reduction:

1. "Reverse V-plasty" (pending publication in peer review medical journal)

2. "Clitoral prepuce segmental resection with edge preservation" (pending publication in peer review medical journal)

Ostrzenski's technique for clitoral hood reconstruction by "Hydrodissection with reverse V-plasty" (pending publication in peer review medical journal).

Ostrzenski's technique of "Reversed clitoral hood reduction" (pending publication in peer review medical journal).

CONCLUSION: Hoodoplasty techniques are simple, easy to learn, and provide very satisfactory esthetic results.

1:35 pm **Labiaplasty of the Labia Minora: Patient Indications for Pursuing Surgery**
JOHN R. MIKLOS, MD

Information not available at press time.

1:50 pm **Labiaplasty of the Labia Majora and Mons Pubis Cosmetic Enhancement**
MARCO A. PELOSI II, MD

The cosmetic surgical treatment of the fatty enlarged mons pubis and labia majora has been poorly understood and therefore often neglected. In other patients, due to pregnancy, weight changes, and aging significant laxity of the pubis region and sagging of the labia majora occur.

The variety of procedures available for the cosmetic enhancement of the labia majora and mons pubis are presented.

2:10 pm **Master Lecture – Personal Strategies for the Prevention and Management of Breast Capsular Contraction and Rippling After Implants**
MARK BERMAN, MD

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

2:40 pm **Aesthetic Reconstructive Vaginal Surgery**
RED ALINSOD, MD

The author's experience combining aesthetic enhancement of the genitalia with surgical repairs of pelvic floor defects will be presented.

3:00 – 3:15 pm **Coffee Break**

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3:15 pm **Vaginal Rejuvenation Techniques**
ADAM OSTRZENSKI, MD

BACKGROUND: This author defines vaginal rejuvenation as a form of gross and functional anatomy transformation to youthful state. Ostrzenski's technique of "Vaginal Rejuvenation" encompasses the following surgical procedures:

1. Site-specific reconstruction of vaginal defects;

2. Vaginal columnar rugae restoration;

3. G-spot surgical augmentation;

4. Vaginal introitus reconstruction with or without perineal body reconstruction.

Occasionally, all of the procedures are implemented in one case and in other cases a selective procedure(s) is elected to best-fit a particular case. It is essential to recognize that vaginal rejuvenation can not be used for the treatment of any form of sexual dysfunction.

STUDY DESIGN: To evaluate Ostrzenski's vaginal rejuvenation technique.

RESULTS: There are different surgical applications of a selected procedure(s) to best-fit a particular clinical situation. A patient selection for an adequate procedure(s) is a key factor in furnishing a patient's request. Among others, the following clinical situations must be recognized in order to assign a patient for an appropriate operation(s):

1. "Acquired sensation of wide vagina," most likely, will require all four surgical procedures to implement in order to achieve satisfactory vaginal rejuvenation results. A surgeon can consider operations such as site-specific reconstruction of anterior, posterior, and central compartments of the vagina, including but not limited to paravaginal reconstruction, which can be executed via transvaginal approach or laparoscopic approach; vaginal columnar rugae restoration; G-spot surgical augmentation; vaginal introitus reconstruction with or without perineal body reconstruction.

2. "Glassy smooth vagina" can benefit from columnar rugae restoration and G-spot surgical augmentation.

3. Decreasing sensation of strokes during vaginal sexual intercourse can profit from G-spot surgical augmentation with or without narrowing vaginal pool.

4. Inherited vaginal deformity or vaginal deformity related to the birth trauma requires individualized approach in selection of surgical procedure(s).

CONCLUSIONS:

1. Ostrzenski's vaginal rejuvenation technique is simple, easy to learn with a short learning curve.

2. Ostrzenski's vaginal rejuvenation provides high patient satisfaction.

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3:45 pm **Penile Triple Augmentation: State of the Art in Phalloplasty**
ALEXANDER A. KRAKOVSKY, MD

INTRODUCTION: Significant shifts in understanding of human sexuality and body images began to occur after Sigmund Freud "opened the bedroom door". Female nudity has been known for centuries as an important marker for fertility but representations of the nude female body are linked to sexual desire and pleasure as well. Images of males, associated with sexuality and fertility, centered on a single element of the male body, namely, the erect penis (phallus). Society's acceptance of female genital cosmetic surgeries increased in popularity for the last 25 years. Society's acceptance of male genital cosmetic surgery has been much slower. Penile Triple Augmentation (the trademark of the author) defines three procedures performed at the same time – penile lengthening, penile widening and penile glans enhancement.

MATERIAL & METHODS: A total of 216 penile triple augmentation phalloplasty surgeries using AlloDerm® and BellaDerm grafts were reviewed. All patients were checked before surgery using H&P, laboratory evaluation and anesthesiology clearance. Some patients required primary care physician clearance that was obtained on demand. All patients were photographed before, during and after surgery. Penis size was measured before and after surgery. The procedure and potential complications were discussed with every patient before surgery; all questions were answered and everybody signed guidelines, follow-ups and consent forms before surgery. Every patient received prescriptions for antibiotics, pain control and erection control medications. Patients were instructed to resume sexual activities of any kind for 8 weeks after surgery.

RESULTS: 63% of the patients who underwent penile triple augmentation phalloplasty surgery with AlloDerm® and BellaDerm grafts and who participated in postoperative survey reported great satisfaction with their cosmetic phalloplasty surgeries. On average, the girth of the penis increased in 30% and penile glans increased in 10% compared with original penile size.

COMPLICATIONS: Infection complications were detected in 11 patients (5.1%). 7 patients required medical treatment for 3 weeks using general and local antibiotics and they were signed off after that with subsequent instructions regarding continuity of care. In 4 patients AlloDerm® graft was removed that cure infection. These patients were monitored for 4 additional weeks and after that they were signed off with subsequent instructions. 23 patients (12%) reported localized swelling up to 2 weeks after surgery that resolved spontaneously. 14 patients (6.5%) reported post-surgical retraction that was treated medically in 12 patients and surgically in 2 patients.

In early stage of penis enlargement surgery free fat transfer (FFT) technique was used. Later on surgeons

used patient's own dermal graft (DFG). Both FFT and DFG techniques have been used for years for penile augmentation. More recently, AlloDerm® and BellaDerm grafts were introduced to the market and became major players in phalloplasty surgery. Information about availability of penile augmentation (phalloplasty surgery), that is now a safe and reliable procedure, has to be delivered to the public and medical community to inform them of surgical technique that improving unsatisfactory sexual performance, relationships, intimacy, and love by increasing the size of a man's penis.

CONCLUSION: The American Academy of Phalloplasty Surgeons is an association of highly qualified medical professionals. The Academy has established international standards for male cosmetic genital surgery, including the identification of indications; operative strategies, surgical techniques; and the assessment of results. The Academy does not consider male cosmetic genital surgery an experimental procedure anymore. Yet, despite successful physical results, the subjective evaluation of aesthetic results and the ethical implications of male cosmetic genital surgery are still debated.

4:15 pm **How the Addition of Cosmetic Services to an OBGYN Practice Results in a More Rewarding and Profitable Practice**
TODD K. MALAN, MD

The author's successful experience will be presented.

4:45 pm **Panel Discussion**

5:30 pm **Session Adjourns**

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WEDNESDAY, JANUARY 27, 2010

SCHEDULE-AT-A-GLANCE

7:00 am – 8:00 pm	**Registration Open**
7:30 am – 8:00 am	**Continental Breakfast**
8:00 am – 5:00 pm	**American Society of Lipo-Suction Surgery Workshop**
8:00 am – 5:00 pm	**Cosmetic Breast Surgery Workshop**
8:00 am – 5:00 pm	**American Society of Hair Restoration Surgery Workshop**
8:00 am – 12:00 pm	**Cosmetic Facial Surgery Workshop**
9:30 am – 10:35 am	**Coffee Break**
12:00 pm – 1:00 pm	**Lunch Break**
1:00 pm – 5:30 pm	**American Society of Cosmetic Laser Surgery Workshop**
3:10 pm – 3:45 pm	**Coffee Break**
5:00 pm	**Workshops Adjourn**

WEDNESDAY, JANUARY 27, 2010

The Art of Liposuction Surgery
Presented by the American Society of Lipo-Suction Surgery
Program Chairman: Robert A. Shumway, MD

Location: Sebastian L1

8:00 am **Welcome & Introduction to Liposuction**
ROBERT A. SHUMWAY, MD

The introduction to liposuction surgery should include many valuable historical lessons including practical tips on "How I Do It." These time-proven formulas will assist every cosmetic surgeon who initiates a strong effort to produce quality liposuction procedures for their properly selected patients. An ASLSS overview of appropriate physician training, methodology, technology, hardware and risk factors will be examined. This includes the author's experience concerning over twenty-two years of past patient exposures. Answers to pertinent liposuction questions like: "What is the best technique?" and "How much do I charge?" and "How do I avoid complications?" will be entertained.

To be frank, there are plenty of solid answers to the manifold questions concerning the modern and sophisticated developments within the grandiose realm of "The Field of Liposuction." For example: ""Who are the right doctors to perform liposuction?" or "Where do I get the best possible liposuction training and credentialing?" The question "How do I match the right patient with the correct procedure?" is a frequent quandary taxing

many lipo-technicians. What methods of liposuction will I use today? What instruments, hardware and technology do I purchase? What are the different types of vacuum lipectomy units available today? What about marketing? How much will it cost to get started? What are the most common risks associated with liposuction and what complications must I absolutely avoid? Are medicolegal issues improving or deteriorating? When will the practice of liposuction become obsolete?

Getting started and developing the medical business of cosmetic liposuction can be very rewarding to any surgeon, to his or her patients, and to their overall practice of cosmetic surgery, if well prepared. By necessity, well organized and thoughtful clinicians will possess and follow a soundly written execution plan to help guide their liposuction practice. The evolution of liposuction within their respective community environments must be foreseen and developed with knowledge and education. In fact, these are the physicians who will most likely succeed in today's business climate. We sincerely hope that this ASLSS course, coupled with your AACS membership, will help provide you with the needed tools for your ultimate success: and that "ultimate success" is patient satisfaction!

8:30 am **New Approaches in Subcutaneous Laser Treatments**
GERHARD SATTLER, MD

The use of the ND YaG laser (Smartlipo) began as a tool for the treatment of lipodistrophy. This application has been supported by many studies demonstrating the disruption of adipocytes, homeostasis, and skin tightening. More recently, this surgical tool is now used in a number of new treatment indications to treat a number of cosmetic body contouring procedures that enhance outcomes and recovery.

This lecture will cover the mechanism of subcutaneous treatment with the laser and new approaches for the use of this tool within a cosmetic practice including the treatment of the face, cellulite, lipomas, and other skin conditions.

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9:00 am **Liposuction Machines and Technology**
JANE A. PETRO, MD

Although the idea of liposuction was elegantly simple in its earliest development, a syringe and a cannula, modern technology has led to a revolution in complex mechanical systems designed to facilitate fat removal. A bewildering variety of cannula themselves exist in the marketplace today. These in turn can be hooked up to negative pressure machines, laser light sources, ultrasound sources, power sources and jet lavage sources. Internal vs. external applications of laser and ultrasound devices exist as well. In the absence of convincing comparative clinical trials, the clinician is at the mercy of the manufacturers, their sales representatives, and demand from potential patients seeking the most recently promoted tool/technique that has appeared on TV/print media. How do you choose what is best for your practice? How do you distinguish a genuine advantage of one over another? While this presentation will not pretend to answer these questions, it will try to sort out the often bewildering array of devices available, and provide a list of pertinent questions to be asked before investing in these often expensive technologies.

9:30 – 10:00 am **Coffee Break**

10:00 am **Liposuction Safety and 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.

10:30 am **Introduction to Laser Lipolysis**
PATRICK G. MCMENAMIN, MD

Sound, scientific tumescent microcannula liposuction, originally developed and pioneered by Jeffrey Klein, MD, is the gold standard in body sculpting. Adding laser energy potentially represents an evolution in technology to gain improved results in fat removal, sculpting and skin tightening.

Varying wavelengths are postulated to represent different degrees of results based on wavelength absorption by the fat, blood vessels, stroma and skin. The induction of heat trauma in the subcutaneous space may result in improved skin tightening especially in areas with varying degrees of dermal thinness (face/triceps/inner thighs) and some authors feel fat removal and hemostasis may be better with laser energy application.

This basic lecture will focus on adding laser lipolysis to established liposuction techniques. Should you add this technology to your practice? Costs, expectations, risks, outcomes, risk/benefit ratios, complications and marketing strategies will be discussed. An honest,

no-spin discussion will occur on the implication of this technology in your liposuction practice.

11:00 am **Laser Lipolysis Pearls**
STEVEN B. HOPPING, MD

Liposuction is one of the most popular cosmetic surgical procedures performed today. Laser Assisted Liposuction or laser lipolysis is the latest development in advanced liposuction techniques. There are two distinct technologies currently being advanced: external (cold), noninvasive lasers and internal, invasive lasers. Both of these technologies were originally designed to be used in conjunction with conventional liposuction surgery rather than stand alone procedures. In the latest development, low level (cold) lasers have evolved to become a stand alone procedure for fat reduction or body thinning (Zerona).

Laser lipolysis was first performed in Europe and South America in the 1990s with a pulsed 1064 nm Nd:YAG laser (SmartLipo, Cynosure, Lipolite, Syneron). This was followed by a continuous wave 980-nm diode laser (Pharaon, Osyris, Hellemmes, France) and a pulsed 1320-nm Nd:YAG laser (CoolLipo, CoolTouch). At the cellular level, laser lipolysis ruptures adipocytes, coagulated small blood vessels and reorganizes the reticular dermis. These tissue interactions may translate into reduced bruising in the acute healing phase and the ability to promote skin tightening.

This paper explores the advantages and disadvantages of laser assisted liposuction, techniques use and improve laser lipolysis, and principals that can reduce adverse results (AEs).

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11:30 am **635 nm External Beam Laser**
GREGORY C. ROCHE, DO

The emergence of non-invasive modalities targeting subcutaneous fat to achieve a slimming effect continues to gain interest amongst physicians and patients. The most recent device, Zerona, is an externally applied low-level laser device that as generated a significant amount of patient interest. Within the medical community, although low-level laser therapy (LLLT) has been proven to be a safe and effective therapeutic option in clinical and histological trials, a great deal of skepticism still remains regarding the efficacy of this modality for non-invasive body contouring. The purpose of this presentation is to discuss the histological and clinical data that supports the application of Zerona for non-invasive body contouring and addressing the major criticism regarding the science of laser therapy.

12:00 – 1:00 pm **Lunch**

1:00 pm **CosmoGYN & Minimally Invasive Lipoabdominoplasty**
MARCO A. PELOSI II, MD

Cosmetic vaginal surgery is a fast growing area of aesthetic surgery. The presentation will cover the nomenclature, functional pelvic floor anatomy, and the variety of surgical procedures available for the cosmetic enhancement of the female genitalia. Many of these procedures are within the skill sets of cosmetic surgeons.

The authors' office-based minimally invasive lipoabdominoplasty system performed under local tumescent anesthesia and its combination with vaginal hysterectomy will be illustrated.

The procedure is associated with minimal morbidity, faster recovery, greater patient satisfaction, and avoidance of complications associated with general anesthesia.

1:30 pm **AFT & Lipo-Shifting Techniques**
SUZAN OBAGI, MD

Fat grafting and liposhifting are useful techniques that can complement liposuction procedures. Fat grafting can be utilized to rejuvenate the face concomitantly with liposuction of the face or body. Alternatively, fat grafting and liposhifting can be used to address liposuction deformities that occur at the time of liposuction (liposhifting) or to correct post-liposuction deformities (liposhifting and fat transfer). The discussion will focus on the order of the procedures and the techniques for performing them.

2:00 pm **Post-OP Liposuction Skin Contour Treatments**
GERALD G. EDDS, MD

Information not available at press time.

2:30 pm **Complementary Fat Grafting**
MARK J. GLASGOLD, MD

The increased popularity of autologous fat grafting for facial rejuvenation has created the need for an algorithmic, easily learned process for this technique. This session will present the aesthetics of volume in defining facial attractiveness and the role of volume loss in the aging process. These concepts will be integrated with the technique of autologous fat grafting for facial rejuvenation. The "volumetric foundation" will be presented as an easily learned step-by-step technique for performing a fat grafting procedure on patients which works as both a stand alone procedure or in a complementary manner with other facial rejuvenation techniques.

3:00 pm **Liposculpture 2010: Volume Reduction and Recontouring with Skin Tightening**
ROBERT H. BURKE, MD, DDS

This presentation will review the experience of the Michigan Center for Cosmetic Surgery with current liposculpture techniques. A paradigm shift occurred with adoption of laser assisted liposculpture in our practice. Indications were revised, reflecting a heavier population with more skin-fascial laxity. Patient expectations also changed – with a desire for minimally invasive procedures and rapid healing.

Three indications will be discussed: minimal lipodysmorphia and little or no skin laxity; moderate to severe lipodysmorphia and varying degrees of laxity ranging from moderate to severe; volume deficiency with skin-fascial laxity.

Safety, outcomes, and complications will be reviewed and discussed. Temperature data obtained during clinical treatment will be reviewed and discussed.

Use in rhytidectomy, male breast reduction, and abdominoplasty will be reviewed and discussed.

NOTES

3:30 pm **Laser Lipolysis: So, Which Wavelength?**
NEIL S. SADICK, MD

Controversy exists as to the optimal target for improving patient outcomes following laser lipolysis. Is the adipocyte, hemoglobin or collagen/water the optimal target chromophore necessary to improve outcomes or are a combination of hybrid wavelengths a better way to achieve the cosmetic surgeon's goal of increased skin tightening, diminished complication profiles and lessened downtime following laser lipolysis procedures? This talk will discuss practical and therapeutic considerations that surround this, as well as histological changes which are noted when varied wavelength adipocyte interactions associated with each of the differential parameters commonly employed by the cosmetic surgeon in the laser lipolysis venue are initiated.

4:00 pm **E-UAL vs. Low Level External Beam Lasers**
JAMES L. ENGLISH, MD,
CAREY J. NEASE, MD,
SUSAN M. HUGHES, MD
AND DOUGLAS D. DEDO, MD

E-UAL: External ultrasound technology has been employed in tumescent liposuction as pre-operative therapy with the goals of improved diffusion of tumescent fluid, improvements in the ease of fat removal and minimizing post-operative morbidity. Over a 6-month period in our office, 15 consecutive patients were treated with External Ultrasound prior to tumescent liposuction of the abdomen. Significant findings included a 33% incidence of seroma formation in the lower abdomen in the early post-operative period in this group. Data were compared to a similar group, a continuous series of 15 patients, who were treated with tumescent liposuction of the abdomen by the same surgeon as the study group but without the ultrasound therapy. This XUAL technique has been abandoned since the findings were noted, and since then I have done either tumescent liposuction alone or laser-assisted lipolysis in over 250 patients with a seroma rate of less than 2%.

Low Level Laser: The efficacy of low level lasers has been well researched and published since the 1980's when Dr. Ed Mester, a Hungarian Otolaryngologist first published his work. Several other scientists have researched the different wavelengths of light on wound healing, and in 1996 Farouk A.H. Al-Watban proved on rats that 635nm of laser light had several positive effects on the rate of wound healing. Compared to controls, the laser treated rats had a 50% faster rate of wound contraction, 20% faster rate of epithelialization and an overall 23% more rapid rate of wound healing compared to controls.

At the 2000 World AACS Liposuction Congress Dr. Rodrigo Neira from Calli Columbia introduced the 635nm low level laser as a tool to facilitate and improve liposuction surgery. His exquisite transmission and scanning electron micrographs of fat treated with this laser demonstrated the changes at the electron microscopic level. Interestingly, a

group of plastic surgeons could not reproduce his results and basically concluded there was no effect on the fat. However, Dr. Lim from Singapore was able to reproduce the electron microscopic changes that Dr. Neira did.

An IRB study was done at several centers to study the effect of this wavelength of light on liposuction patients. From this multi-center study it was determined that the treated patients had less pain, ease of fat extraction was enhanced and bruising was less. As a result of this study it was the first and for a period of time the only laser approved by the FDA for liposuction.

From the literature and personal clinical experience I believe the 635 low level laser offers substantial benefit to all cosmetic surgical patients. Fact: It affects wound healing and as a result all of my patients are treated intra-operatively, immediately post operatively, and whenever they are seen in the office after surgery up to two weeks. Fact: It "softens" fat cells. From the histological studies previously described, I have found clinically the suctioned fat is emulsified and less bloody. Fact: This wavelength of light reduces the work of removing the fat. The combination of reduced operating time and ease of fat removal has made low level laser liposuction a more efficient and less tiring procedure.

In conclusion, there is neither hope nor hype with respect to the efficacy of low level lasers. Solid scientific research has substantiated the usefulness of low level lasers and specifically the wavelength of 634nm.

4:30 pm **Panel Discussion**

5:00 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: Sebastian L2

Moderator: ROBERT M. DRYDEN, MD

8:00 am **Welcome and Introduction to Cosmetic Breast Surgery**
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 and 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 examination should be conducted in a relaxed but professional manner in the presence of a chaperone. 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. Included in the evaluation should be preoperative photographs.

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, bleeding and ecchymosis 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 and bleeding. Postoperative swelling and postoperative long-term pain appear to be significantly reduced.

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

Information not available at press time.

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.

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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). Four 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. 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: JACOB HAIAVY, MD, DDS

9:55 am **The Roy Morgan Appreciation Lecture – Augmentation Pearls**
ROBERT F. JACKSON, MD

During this session the attendee will benefit from the author's experience of over 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 pre-operative 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. The treatment of difficult cases and those that should be avoided will be discussed. Post-operative care, exercises, and correction or treatment of complications will be addressed.

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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 **Capsular Contraction**
MAURICE P. SHERMAN, MD

Information not available at press time.

10:50 am **Transaxillary Subfascial Augmentation**
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.

11:10 am **Inframammary and Areolar Breast Augmentation**
MAURICE P. SHERMAN, MD

The two most common surgical approaches used in breast augmentation are discussed with emphasis on correct techniques to avoid problems.

11:30 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; this can lead to palpability and rippling of the implant, two common and unwanted sequelae. Understanding this technique and the anatomical approach will give you another tool for successful breast augmentation.

11:50 am **Panel Discussion**

12:00 – 1:00 pm **Lunch**

Moderator: RONALD A. FRAGEN, MD

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

Transumbilical Breast Augmentation (TUBA) coupled with the "Extended Crescent" or "Bernelli" periareolar nipple-areolar-complex (NAC) lift are effective procedures for aesthetically correcting early to moderately severe breast ptosis. The overall physiological aging process, which also includes the effects of pregnancy and breastfeeding, appears to accelerate the atrophy of internal breast parenchyma and to increase the laxity of the external skin envelope of the ptotic breast. Also, dramatic weight changes in women are known to cause extensive adipose tissue shifts that affect the overall shape of the mammary glands. Therefore, the author will display an array of clinically different ptotic breasts which are suitable for treatment by the above combination surgeries while using TUBA techniques.

The results from a large fifteen-year retrospective breast study reveal the highly successful use of TUBA & NAC mastopexy for glandular ptosis, grade I ptosis, grade II ptosis, and for patients who require breast shaping. Utilizing TUBA eliminates the need for deep through-the-breast approaches of breast implantation. Additionally, using the Extended Crescent NAC Lift techniques allow for well camouflaged non-invasive breast envelope tightening, NAC elevation, NAC shifting for better symmetry, and areolar reductions if so needed. Before and after photography will be evaluated with an emphasis on long-term appearance.

The presenter will further detail the pearls and pitfalls of TUBA with adjunct procedures such as liposuction and mastopexy. Both the novice and expert TUBA surgeon alike will benefit from the discussion of avoidable problems and progressive healing concerns. All in all, the TUBA operation keeps the surgical incision away from the breast and allows for reshaping of the mammary glands. The NAC Mastopexy Lift keeps any needed breast incisions superficial and well hidden around the areola. These procedures are very powerful surgical tools that offer excellent results for the dedicated cosmetic breast surgeon.

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1:20 pm **Transaxillary Mastopexy**
ROBERT M. DRYDEN, MD

Many patients avoid having a traditional mastopexy due to the extent of the surgery and 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.

1:40 pm **Breast Augmentation Complications**
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.

2:10 pm **Mastopexy for Beginners**
THEODORE STAAHL, MD

The essential steps for breast lifting or mastopexy will be reviewed. Patient selection for the various procedures is important. The measurements of normal and abnormal breasts will be shown. The crescent lift, round block or Benelli lift, and the vertical mastopexy will be elaborated upon. Detailed operative steps will be projected in a PowerPoint format. Also problems and complications will be discussed. The author's personal approach to vertical mastopexy will be shown, as well as breast reduction.

2:50 pm **Gynecomastia and Stem Cell Breast Augmentation**
JEFFRY B. SCHAFER, MD

36-40% of men have gynecosmastia and it is an embarrassing development. Direct excision has been the "gold standard" but now laser-assisted liposuction has eliminated periareolar scars and skin laxity. Step by step techniques will be discussed including Micro-Aire and Body-Jet techniques.

Newest techniques for female breast augmentation using Fat/Stem Cell Augmentation using the Lipo-Kit and Max-Stem technology for harvesting and concentration stem cells, growth factors and other precursor cells.

3:10 – 3:30 pm **Coffee Break**

Moderator: PATRICK G. MCMENAMIN, MD

3:30 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.

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3:50 pm **Revisions and Refinements in Cosmetic Breast Surgery**
JACOB HAIAVY, MD, DDS

Cosmetic breast surgery has consistently been one of the most common cosmetic surgical procedures performed in the United States. Last year it climbed to number one status with over 350,000 performed in the US. Even though the satisfaction rate reported is over 95%, the revision rate reported to the FDA is quite high, 20%, within 3-5 years. In this session we will review some of the factors contributing to this revision rate and some techniques to avoid or treat them.

The subjects we will discuss include implant leakage, capsular contracture, implant malposition inferiorly, medially and laterally without capsular contracture, synmastia and double bubble. We will discuss possible risk factors for each and possible treatment options. Multiple cases with before and after pictures will be demonstrated. We will demonstrate our technique of capsulorrhaphy for correction of implant malposition and report on our patient's experience with the technique.

4:15 pm **Current Considerations in Breast Cancer and Breast Biopsy**
JANE A. PETRO, MD

Information not available at press time.

4:30 pm **How to Avoid Lawsuits**
RONALD A. FRAGEN, MD

Lawsuits can be prevented by patient communication and rapport. Special techniques are applicable to difficult and or non-compliant patients. If complete and caring communication is established patients, even though the results are not perfect, are much less likely to institute legal action.

4:50 pm **Questions and Answers**

5:00 pm **Session Adjourns**

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THE ART OF HAIR RESTORATION SURGERY

Presented by the American Society of Hair Restoration Surgery
Program Chairman: Robert V. Cattani, MD

Location: Sebastian L3

8:00 am **Welcome and Introduction to Hair Restoration**
ROBERT V. CATTANI, MD

8:15 am **Selecting the Best Candidates for Hair Restoration Surgery**
MARCO N. BARUSCO, MD

The objective of this session is to review basic and advanced concepts that are essential when considering a patient for a hair restoration procedure. At the end of the lecture, participants will be able to determine with accuracy whether someone is a good, marginal or poor candidate for surgical hair restoration.

In the lecture I will discuss such factors as age, type of hair loss, pattern of current hair loss, implications of future hair loss in the surgical plan and risk assessment for this procedure.

8:30 am **Hairline Design**
PAUL T. ROSE, MD

Construction of the hairline incorporates not only the technical skills of hair restoration surgery but the aesthetic skills as well. It is within the hairline that the hair replacement physician can excel as an artist.

By examining the hairline in those who have retained their hair one can discern various factors that are important in constructing a natural appearing hairline. In this lecture we will discuss some of the factors that the hair transplant surgeon must take into account to construct the hairline. We will discuss factors such as placement, irregular irregularity, clustering, graded density, island hairs, correct caliber, and other components.

8:45 am **Female Hairline Design**
ROBERT H. TRUE, JR., MD

Women are the most rapidly growing segment of the hair transplant population. While restoration is most commonly performed in area of hair loss following the Ludwig pattern, many women will present for restoration of their hairline.

Common conditions leading to loss of the hairline are traction alopecia, androgen excess or sensitivity, cosmetic procedures such as brow and upper face lifts, angular alopecia, and postmenopausal hairline recession. In the absence of hair loss, women born with high, “male” shaped hairlines present commonly requesting creation of a more feminine hairline.

Feminine hairlines have many characteristics different from those of male hairlines. It is essential that these critical design elements are part of hairline restoration for women.

The author will present several case examples in illustration of key principles in female hairline restoration.

9:00 am **Beginners Panel**

Moderators: ROBERT V. CATTANI, MD AND STEVEN B. HOPPING, MD

Panelists: E. ANTONIO MANGUBAT, MD, PAUL T. ROSE, MD, ROBERT H. TRUE JR., MD AND MATT L. LEAVITT, DO

9:45 am **Surgically Lowering the Hairline of Women**
SHELDON S. KABAKER, MD

This procedure is best done for those women with hereditary high hairlines and flexible scalps. This operation is not recommended for those with progressive hair loss problems. The indications and the technique will be described in detail. A video presentation is included.

10:05 am **Integrating Hair Restoration Surgery into your Practice**
E. ANTONIO MANGUBAT, MD

Information not available at press time.

10:20 – 10:35 am **Coffee Break**

10:35 am **Clinical Applications of Follicular Unit Extraction**
ROBERT H. TRUE, JR., MD

Follicular Unit Extraction (FUE) has emerged as a useful addition to hair transplantation practice. Many hair transplant practices routinely perform the technique and see FUE as a complementary approach to the more routinely performed strip Follicular Unit Transplantation (FUT).

In FUE individual follicular units are extracted utilizing punches ranging from 0.7 mm to 1.1 mm in diameter. There are many variations of the technique ranging from manual punches (both sharp and dull) to fully automated systems. Although manual technique dominated in the early phase of development of FUE since 2001 there is now a general confluence toward some kind of mechanization among experienced practitioners.

The author will present his and these various techniques, present cases studies of a variety of clinical applications, and give a detailed comparison of FUE vs. FUT with special attention to advantages and disadvantages of both procedures.

11:00 am **Hair Technician's Panel**

Panelists: E. ANTONIO MANGUBAT, MD AND MATT L. LEAVITT, DO

12:00 – 1:00 pm **Lunch**

1:00 pm **Grand Masters Panel**

Moderators: ROBERT V. CATTANI, MD AND STEVEN B. HOPPING, MD

Panelists: JAY G. BARNETT, MD, SHELDON S. KABAKER, MD AND MATT L. LEAVITT, DO

2:00 pm **Current Concept of Medical Therapies**
MATT L. LEAVITT, DO

Information not available at press time.

2:15 pm **Transplanting the Crown: When and How**
MARCO N. BARUSCO, MD

The objective of this session is to discuss advanced techniques for restoration of hair loss in the vertex area of the scalp (also known as "Crown").

Patient consultation, candidate selection, patient expectations, planning for future hair loss, contra-indications for the procedure, normal anatomy and hair distribution of the vertex area, surgical planning and execution will be discussed in detail, giving the participants a complete overview of the techniques used to restore this important cosmetic area.

2:30 pm **Repair of Suboptimal Hair Restoration Procedure**
E. ANTONIO MANGUBAT, MD

Information not available at press time.

2:45 pm **Combining Medical and Surgical Therapy for Optimal Hair Loss Treatment**
MARCO N. BARUSCO, MD

This session will discuss the advantages of medical and surgical therapies for Androgenetic Alopecia.

The latest data on current FDA-approved treatments, treatment efficacy, contra-indications, side effects and expectations of medical therapy will be addressed in detail, as well as indications for medical therapy as a single modality or in combination with surgical treatments.

3:00 pm **Scalp Reconstruction from Illness or Injury**
E. ANTONIO MANGUBAT, MD

Information not available at press time.

3:15 pm **Donor Harvesting**
PAUL T. ROSE, MD

Currently two techniques, strip harvesting and follicular isolation or follicular unit grafting, are used for donor harvesting. Both of these techniques allow for the harvesting of follicular unit grafts. In this lecture we will review the evaluation of the donor area and a way to calculate the amount of tissue to be harvested for strip harvesting. We will also review the surgical technique for harvesting tissue with a strip method and the use of a tricophytic closure as well the technique for FIT/FUE. We will review the advantages and disadvantages of these varying approaches to donor harvesting.

3:30 – 3:45 pm **Coffee Break**

3:45 pm **Techniques in Scalp Expansion**
E. ANTONIO MANGUBAT, MD

Information not available at press time.

4:00 pm **Consultation in Dermatologic Disorders**
PAUL T. ROSE, MD

The evaluation of hair loss in most cases is relatively straightforward. There are however instances where the cause of hair loss in males and females requires more extensive investigation. There are many dermatologic disorders that can cause hair loss and the clinician must be able to recognize the different forms of scarring and non-scarring hair loss.

In this lecture we will discuss how to diagnose and treat some of the more common disorders that cause scarring hair loss as well as those that are non-scarring.

The appropriate workup for female hair loss will also be discussed.

4:15 pm **Complications Panel**

Moderator: PAUL T. ROSE, MD

Panelists: SHELDON S. KABAKER, MD, ROBERT H. TRUE JR., MD AND E. ANTONIO MANGUBAT, MD

5:00 pm **Session Adjourns**

THE ART OF COSMETIC FACIAL SURGERY

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

Location: Sebastian L4

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

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

Facial aging is a combination of the effects of gravity and atrophy. This paradyne shift in philosophy has led to a revolution in the treatment of the aging face by volumetric filling, with fat, synthetic fillers, and alloplastic implants. In many patients, volumetric filling is more important than lifting. This group of patients can benefit from filling techniques, thereby avoiding or postponing facelifting.

Modern facelifting is almost always accompanied by filling with fat or implants. Traditional SMAS facelifting provide two-dimensional lifting of the soft tissues of the face. SMAS procedures are less effective at replacing diminished facial volume. Facial rejuvenation with alloplastic implants can give permanent volumetric restoration which when combined with SMAS lifting achieves a three-dimensional lift. The concept of three-dimensional facelifting focuses on (1) skeletal enhancement with alloplastic implants, (2) SMAS lifting and repositioning by placation or imbrication and (3) skin rotation and redraping. In many patients, all of these elements must be addressed to achieve the optimal aesthetic result.

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 **Laser Facelift Paradigm**
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.

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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 performed alone or in conjunction with a lower facelift. A well performed submentoplasty in the appropriate patient can have a major 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 (the obtuse neck) 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.

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

HISTORY: About 80 years ago Dr. Passot and Dr. Joseph 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. 1998 The author has 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 compared to the early cases. This presentation will emphasize the improvement of a minimally invasive technique developed and utilized successfully by the author over the past twelve years. The main differences are: The missing tumescent anesthesia and the skin excision in front of the ears previous to surgery. A third pulse string formed plication under the earlobe and different suturing materials. Also a serial Platysma notching and an extended neck dissection is performed in older patients to achieve better results. At this cases the incision is similar to a conventional facelift and the surgery is than called as 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 with "U" and "O" formed sutures, 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 scarring, 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 1999 and 2008 are as follows:

- The skin excision previous to surgery is not performed anymore. 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 anesthetic 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 so called "Z" suture is inserted below the earlobe pulling the platysma and the neck backwards to achieve a better submental angle. Blowing up the face (Hydrodissection) with tumescent solution is no longer performed and the S-Lift is now combined with submental liposuction, platysmaplasty, serial platysma notching and facial rejuvenation with fractional lasers and stem cells.

11:15 am **Complications**
H. GEORGE BRENNAN, MD

Information not available at press time.

11:35 am **Panel Discussion**

12:00 – 1:00 pm **Lunch**

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Location: Sebastian L4

New Technologies Utilizing Light and Radiofrequency

1:00 pm **Introduction and Overview**
NEIL S. SADICK MD AND
WILLIAM H. BEESON, MD

1:10 pm **Laser Lipolysis**
ROBERT A. WEISS, MD

New generation laser and radiofrequency technologies utilized for laser RF assisted lipolysis will be highlighted. Indications, scientific principles and clinical studies will be emphasized.

1:40 pm **Cellulite**
WILLIAM H. BEESON, MD

New aspects of pathophysiology and epidemiology of cellulite will be covered. Laser, radiofrequency and LED sources will be expounded upon. Treatment protocols, combination approaches and patient expectations will be highlighted.

2:10 pm **Body Contouring /Tightening**
STEVEN B. HOPPING, MD,
ROBERT F. JACKSON, MD
AND DOUGLAS D. DEDO, MD

Anatomic areas of non-facial skin tightening efficacy will be covered. The utilization of new generation broadband light sources and radiofrequency technologies will be highlighted.

2:40 –
3:00 pm **Coffee Break**

3:00 pm **Non-invasive Lipolysis**
GERHARD SATTLER, MD

Advanced low energy lasers, high intensity focused ultrasound and cryolipolysis technologies including present FDA status will be covered. Clinical studies, mechanism of action and worldwide experience for non-invasive lipolysis technologies, which are gaining increasing popularity, will be presented.

3:30 pm **Endovenous Lasers for Treatment of Cosmetic Varicosities**
PAUL T. ROSE, MD

Various wavelength endovenous technologies will be expounded upon. Treatment approaches and avoidance of complications will be covered.

4:00 pm **New Generation Fractional Laser Technologies**
PAUL J. CARNIOL, MD

First-generation and second-generation microablative fractional technologies will be covered. Treatment protocols, clinical indications and the science of surrounding fractional laser devices will be discussed. Differential aspects of various wavelengths of fractional technologies will be expounded upon.

4:30 pm **Indications for Photodynamic Therapy**
SUZAN OBAGI, MD

Photodynamic therapy is playing an increasingly important role in the management of acne, photodamage and superficial skin cancers. New generation photodynamic agents will be discussed. Treatment protocols and appropriate light source options post treatment will also be emphasized.

5:00 pm **State of the Art Laser Hair Removal 2010**
NEIL S. SADICK, MD

New high powered laser sources for photoepilation will be discussed and updated aspects of basic the science of laser hair removal will be expounded upon. Optimal treatment protocols for skin and hair phenotypes will be included.

5:30 pm **Workshop Adjourns**

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THURSDAY, JANUARY 28, 2010
THE ART OF FACIAL COSMETIC SURGERY

SCHEDULE-AT-A-GLANCE

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

THURSDAY, JANUARY 28, 2010

7:00 – 8:30 am BRIGHT EYE SESSIONS: 101
(Sessions will run concurrently)

BREAKOUT #1

Location: Wekiwa 1&2

Lasers and Fillers

Neil S. Sadick, MD and Ronald L. Moy, MD

New generation fillers and light sources have enhanced patient care cosmetic surgery products with a trend toward pan focal volumetric fillers. Customized fillers that are site specific and bioactive stimulating dermal remodeling lead the newest approaches of filler technology.

Newer generation light sources include second generation fractional lasers, enhanced radiofrequency and ultrasound skin tightening technologies and whole body rejuvenation, body remodeling and nonsurgical lipolysis approaches.

These topics will be covered in detail in this all-encompassing overview of the latest in laser and filler treatments including fractional devices (both ablative and non-ablative), radiofrequency devices, and newer injection techniques for fillers. Optimizing botulinum toxins with attention to natural, relaxed results, and radiofrequency nerve ablation will be highlighted. This discussion will be interactive and audience participation will be encouraged to maximize active learning.

BREAKOUT #2

Location: Wekiwa 3&4

Facelifting 2010, Current and Future State of the Art
Steven B. Hopping, MD and Ziya Saylan, MD

Facial rejuvenation remains one the most frequent request of cosmetic patients. Today's patients are generally very sophisticated and knowledgeable about the latest techniques and technologies. They seek procedures offering less risks and recovery than many historical facelifting procedures. Many are willing to sacrifice the ultimate aesthetic goal for safety and minimal scars. This discussion is an interactive, in-depth review of current "safe" techniques of facial rejuvenation including minimal incision procedures, short scar and segmental facelifting. Strong emphasis on the avoidance and treatment of complication will be included. Future directions in facial rejuvenation including low level (non invasive) laser, laser assisted facial techniques, and "stem cell" facial rejuvenation will be discussed as well.

It is the objective of this seminar to educate the novice and experienced cosmetic surgeon in safe techniques of facial rejuvenation and the avoidance and treatment of untoward results.

The authors will present their techniques and experience will current facial rejuvenation procedures with didactic and video illustrations. A range of expected results with these various techniques will be presented. Complications, treatment options and outcomes will be illustrated.

There are many safe options for facial rejuvenation in 2010. The cosmetic surgeon should be familiar with the safety profile, recovery, advantages, disadvantages, and complications of these techniques to effectively treat requests of today's cosmetic patient.

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BREAKOUT #3

Location: Wekiwa 5

Revisions and Refinements in Cosmetic Breast Surgery
Jacob Haiavy, MD, DDS, Brent Rosen, DO
and Clayton Frenzel, DO

Cosmetic breast surgery has consistently been one of the most common cosmetic surgical procedures performed in the United States. Last year it climbed to number one status with over 350,000 performed in the US. Even though the satisfaction rate reported is over 95%, the revision rate reported to the FDA is quite high, 20%, within 3-5 years. In this session we will review some of the factors contributing to this revision rate and some techniques to avoid or treat them.

The subjects we will discuss include implant leakage, capsular contracture, implant malposition inferiorly, medially and laterally without capsular contracture, synmastia and double bubble. We will discuss possible risk factors for each and possible treatment options. Multiple cases with before and after pictures will be demonstrated. We will demonstrate our technique of capsulorrhaphy for correction of implant malposition and report on our patient's experience with the technique.

BREAKOUT #4

Location: Wekiwa 7&8

Liposuction Techniques
Gerhard Sattler, MD and E. Antonio Mangubat, MD

Information not available at press time.

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

9:15 – 9:30 am Opening
Welcome by Patrick G. McMenamin, MD
AACS President

9:30 am – 12:00 pm General Session 102: Facial Cosmetic Surgery

Moderators: SUSAN M. HUGHES, MD AND JEFFREY C. POPP, MD

9:30 am Recognizing and Treating the Commonest Form of Blepharoptosis
ROBERT M. DRYDEN, MD

OBJECTIVE: Recognizing and managing the commonest form of blepharoptosis should be an integral part of the armamentarium of every cosmetic surgeon who does eyelid surgery.

METHOD: The aponeurotic dehiscence that causes this common form of blepharoptosis creates a high pull on the eyelid and often a higher eyelid crease while maintaining normal levator function. Illustrative photographs will show the signs of an aponeurotic blepharoptosis as well as also show the potential problems of inferior scleral show and strabismus. Each of these problems may cause the patient complications with correction of the ptosis condition.

The surgical correction of the presenting blepharoptosis will also be illustrated.

RESULTS: Preoperative and postoperative patient photographs will illustrate the desired results of blepharoptosis surgery.

CONCLUSIONS: Every cosmetic surgeon that performs cosmetic eyelid surgery should recognize and be able to treat blepharoptosis caused by an aponeurotic dehiscence. The signs of this commonest form of blepharoptosis as well as the surgical procedure to correct it will be presented.

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9:40 am **Effect of Upper Blepharoplasty on Eyelid and Brow Position**
TANUJ NAKRA, MD

OBJECTIVES: To compare upper eyelid and brow position before and after upper blepharoplasty without ptosis surgery.

METHODS: The medical records of the participants were retrospectively reviewed. Specialized facial analysis software was developed and utilized to quantify the upper margin reflex distance (MRD1) as well as brow position from clinical photographs. The main outcome measures were preoperative and postoperative MRD1 measurement as well as preoperative and postoperative brow position measurement.

RESULTS: A total of 30 patients (59 eyelids) met the inclusion criteria. The mean preoperative MRD1 was 2.8 mm, and the mean post-operative MRD1 was 3.5 mm, for an average increase in MRD1 after upper blepharoplasty of 0.7 mm (p=2.8 x 10-7). The mean preoperative brow position was 17.9 mm above the pupil, and the mean postoperative position was 17.7 mm, for an average change in position after upper blepharoplasty of -0.2 mm (p=0.18).

CONCLUSIONS: Upper blepharoplasty without ptosis surgery results in a predictable increase in MRD1. Brow position does not change significantly in patients who undergo upper blepharoplasty for simple dermatochalasis.

9:50 am **Cosmetic Eyelid Surgery, A Multiangular Approach**
DARAB HORMOZI, MD

OBJECTIVES: Presenting a multi-angle approach to eyelid surgery based on 17 years of surgical experience. The goal of cosmetic eyelid surgery should be, foremost, to preserve the integrity and function of the eyelid and provide complete protection of the eyeball. Unless desired, the shape and expression of eyes should not be modified. The position of the eyebrow needs to be addressed and the lower eyelid tendons and ptosis of the cheeks need to be corrected.

METHODS: Using minimally invasive procedure and Radio-Surgery (Ellman International unit), cosmetic eyelid surgeries are performed under pure local anesthesia. The methods of evaluation of the lower lid laxity and eyebrow position is demonstrated. Tear trough deformity is addressed and the resulting plan of surgery is shown through photos and video clips.

RESULTS: The preoperative and postoperative photos of different surgical approaches are shown and the necessity to preserve the natural and individual shape of the eyes are demonstrated.

CONCLUSIONS: A properly planned, multi-angular approach to cosmetic eyelid surgery should preserve the shape and expression of the eye. It should not compromise the function of the eyelid or unnecessarily expose the cornea. Lower lid retraction, lagophthalmos and eyebrow ptosis should not be part of expected outcome of Blepharoplasty. The goal of the Blepharoplasty is to produce a younger, fresher look but not to change the expression of eyes and face.

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10:00 am **eCO2 Fractional Laser on Bilateral Lower Lid Dermatochalasis**
AMINA HUSAIN, MD

OBJECTIVES: Carbon dioxide laser resurfacing has enjoyed a recent revival with the introduction of computer pattern generators that provide fractional resurfacing. The Lutronics Inc. laser allows this type of resurfacing to be done with 120 microns, 300 microns and 1000 microns spot sizes. The purpose of this study is to assess the ability to this laser to improve lower eyelid rhytides in Fitzpatrick skin types I through IV with both the 120 micron and the 300 micron tips at different fluences and densities.

METHODS: Retrospective chart review of patients undergoing bilateral lower lid laser resurfacing with the Lutronics eCO2 laser at the Duke Aesthetics Center. Charts were analyzed from January 2009 to July 2009. Photos and clinic visits were analyzed in terms of laser settings, Fitzpatrick grade, erythema, re-epithelization date, scarring, wrinkling, telangiectasias, dyschromia, pores, and patient satisfaction. Data was analyzed from day of procedure, post-operative week 1, month 1, month 3, and month 6.

RESULTS: A total of 35 patients were analyzed in this study. The settings used with 120 micron tip varied from 80 mJ to 110 mJ with density of 100-200 spots per cm^2. The settings used with the 300 micron tip ranged from 100 to 120 mJ with density of 100-200 spots per cm^2. Two of the patients were Fitzpatrick skin type IV, both of Asian descent. Only one was treated with hydroquinone for a short period of time; no problematic hyperpigmention occurred. Erythema greatly improved by month 1 and resolved in 90% of patients by month 3. Re-epithelization occurred anywhere from 5 days to 7 days. No significant changes were noted in scarring, telangiectasias, or pore size. No significant dyschromia or other adverse effect was noted in any of the patients. Wrinkling was significantly reduced in all patients. 85% of patients reported greater than 75% satisfaction with the end results. Please note, more results to follow.

CONCLUSIONS: Lutronics eCO2 fractional laser uses a 120 or 300 microns spot size that allows deeper penetration with less total surface area ablation than older generation CO2 lasers. The majority of the patients reported very good satisfaction with the procedure and no long term complications were noted. Thus far, this laser is a safe and effective means of reducing lower lid rhytides.

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10:05 am **Laser Assisted Lower Eyelid Blepharoplasty (SmartEyes™) Utilizing a 980nm Diode Laser and Modified Tumescent Technique**
TODD K. MALAN, MD

OBJECTIVES: To evaluate the safety and efficacy of utilizing a 980nm diode laser for the purpose of performing a lower lid blepharoplasty.

METHODS: 20 patients were selected for lower lid blepharoplasty based on demonstrated pseudoherniation of the lower orbital fat pad and accompanying skin laxity. Utilizing a modified tumescent technique, a 980nm diode laser was utilized in an attempt to emulsify sub-orbital fat pad and to promote lower lid dermal fibrinolysis. Patients were followed at 1, 4, 6 and 12 weeks intervals to evaluate photographic evidence of improvement as well as patient satisfaction scores.

RESULTS: All subjects reported a significant improvement in lower lid laxity. The majority also noted completed resolution of sub-orbital fat pad protrusion. No major complications were observed. Minor thermal trauma were noted without long term sequela.

CONCLUSIONS: Lower eyelid blepharoplasty is often the treatment of choice for patients who have bags or puffiness under the eyes. This deformity is frequently a result of pseudoherniation of the orbital fat. Skin Laxity and rhytides may contribute to the overall perception of the deformity. Dark circles resulting from lower orbital venous stasis are also frequently encountered. Traditional blepharoplasty techniques seek to rejuvenate and restore the lower lid area by excision of the orbital fat pad pseudoherniation excess lower lid tissue. Traditionally, the anterior transcutaneous approach is preferred for this procedure. This technique provides excellent exposure to the orbital fat, and the resultant scar is minimal. Unfortunately, the approach is associated with many complications. The most common of which is inadequate fat removal and consequent patient dissatisfaction. Laser assisted lipolysis techniques have been demonstrated to be useful adjuvants to the emulsification and removal of fat as well as in the tightening of skin. In our experience, lower eyelid laser assisted blepharoplasty (SmartEyes™) utilizing a 980nm diode laser and modified tumescent technique offers the ability to safely emulsify the lower eyelid fat pad, reduce skin laxity and rhytides, and promote venous coagulation.

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10:10 am **Effective Therapy for Cheekbags/Festoons and Ectropion: Deep Double Anchor (DDA)**
AFSCHIN FATEMI, MD

OBJECTIVES: Classic therapy for festoons or cheekbags is direct excision. But not every patient likes the idea of having scars in a visible spot. Ectropion as a challenging problem. Solution for ectropion is not very simple.

METHODS: The presentation is about a new and simple technique, called Deep Double Anchoring, that provides an effective and long lasting therapy not only for cheekbags, but also for festoons and for ectropions. The technique is a modified midface lift, starting with a typical lower lid approach, then proceeding with a septal reset, a combined canthopexy and lid ligament fixation, and an additional second anchoring of the lateral part of the orbicularis muscle to the deep temporalis fascia.

RESULTS: Case- and intra-surgery presentation, 3ys follow-up. Complication rate is low, the most feared complication besides all trivial complications is ectropion.

CONCLUSIONS: Deep Double Anchor is a simple and safe technique, suitable for the treatment of festoons/cheekbags and ectropions.

10:15 am **A Novel Blepharoplasty Technique for Tear-trough Effacement with Insufficient Fat for Repositioning or Redraping**
MARK T. DUFFY, MD, PHD

OBJECTIVES: To report a novel surgical technique that can address patient desires where established techniques may not apply. Among the most common consults in my office is what ultimately turns into treatment of nasojugal and tear trough deformities. The most common method of treatment for me has become preperiosteal hyaluronic acid injections into the hollows. Frequently this is extended into the malar area for midface support as well. For patients with significant dermatochalasis or severe herniated orbital fat, my procedure of choice is lower blepharoplasty with complete excision of the orbital septum and draping of the orbital fat into the deformity. This works exceptionally well for even the deepest of deformities. However, I have occasionally encountered a patient who has insufficient orbital fat for repositioning who doesn't want injections which need periodic repeating.

METHODS: In two such cases I have performed the external lower lid blepharoplasty and used Enduragen (1.0mm thick: Porex) to fill in the tear and nasojugal trough deformities. The first patient had two previous blepharoplasties elsewhere with severe hollows and mild dermatochalasis. The second patient had congenital deep tear trough deformities. Both patients had insufficient herniated orbital fat for redraping. The procedure was performed in the same manner as my standard lower

external blepharoplasty. The septum was still excised to allow any prolapsed orbital fat to drape inferiorly as well as decrease the risk of retraction postoperatively. At this point the periosteum is incised outside the arcus marginalis and a subperiosteal dissection is made. The extent of the undermining is determined by the depth and width of the hollow. This dissection is similar to the procedure described originally by Allen Putterman to place the orbital fat pads subperiosteally with a full-thickness prolene suture. Instead of fat pads, I cut out a curved piece of Enduragen™ to follow the curve of the external orbital rim and maxillary bone. In the two cases performed so far, the hollow was sufficiently deep that two pieces were stacked on top of each other. The Enduragen was fixated in place with 5-0 chromic interrupted sutures to the periosteal edge. This was simply to prevent any dislocation postop. No full-thickness sutures were placed. The edges of the periosteum did not cover the superior edge of the implant in order to promote vascularization and presumed longevity of the implant.

RESULTS: Postoperatively the patients' courses were unremarkable and demonstrated good effacement of the nasojugal troughs. There were no complications and the patients were pleased with the results (photos will be shown). In retrospect, the second person could have used a third layer of Enduragen on the left side but the patient was still quite pleased with the results.

CONCLUSIONS: In cases of dermatochalasis with tear trough and nasojugal hollows and insufficient fat for redraping (or in patients who decline filler), Enduragen placement may be a reasonable alternative to a permanent static artificial implant.

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10:20 am **The Use of Liquid Injectable Silicone to Treat Facial Scars and Defects Including Rejuvenation**
JAY G. BARNETT, MD

Following a limited history of the use of liquid silicone injections for improving facial scars and defects, various topics exhibiting the precision and long-term value of liquid Injectable silicone will be presented. Among the topics to be discussed will be:

(A) The FDA-approved liquid silicone products available for "off label" use.

(B) The technique if injection including the needles and syringes that can be utilized.

(C) Numerous before and after photos of the treatment of facial scars, acne scars and nasal defects with long term follow-ups of up to 30 years.

(D) Lip augmentation techniques and results.

(E) Rejuvenation of eyelid grooves and tear-through deformities.

(F) Rejuvenation of aging facial grooves and facial volume loss including HIV facial atrophy.

Concluding comments will include potential complications and suggestions to the doctor on how to avoid complications and obtain maximum beneficial results using liquid Injectable silicone.

10:40 am **Endotine Trans Bleph for Brow Lift – A Review of 50 Cases**
MOHAN THOMAS, MD

OBJECTIVES: The endotines Trans Bleph device made by Coapt systems is a bio absorbable fixation method for forehead and brow lift. The endotines suspension for endoscopic brow lift has been in use since 2003 and is well accepted in endoscopic forehead rejuvenation.

The Trans Bleph device is meant for non endoscopic brow lift using upper blepharoplasty approach. We evaluated the utility of this device in 50 cases of brow lift.

METHODS: 50 cases of brow ptosis were treated by brow lift using upper blepharoplasty incision and fixation using the endotines Trans Bleph device. The Trans Bleph device is fixed to the frontal bone just above the orbital rim, the exact position of which is determined preoperatively in the sitting position. The device is placed just lateral to the pupillary line. The subcutaneous tissue beneath the lateral brow is engaged to the endotine to achieve the brow elevation. The forehead is taped in position for a week.

RESULTS: An average of 2.2 mm elevation could be achieved using this method. The results were maintained

in the follow up ranging from 8-15 months. All patients were happy with the amount of brow elevation achieved. Problems encountered include palpability of the implants (5 cases), numbness over the area (4 cases) and slipping of the implant (2 cases). The palpability of the implant decreased over 4-6 months and did not require implant removal. Frown lines if present require Botulinum toxin injections. The procedure takes more time to complete when compared to the percutaneous suture suspension brow lift described by the author.

CONCLUSIONS: The endotine Trans Bleph device is a useful adjunct in forehead rejuvenation, especially when combined with upper blepharoplasty. The technique is easy to learn and employ and provides stable adequate elevation of the brows.

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10:47 am **Ultratine Breakage**
AARON SAVAR, MD

OBJECTIVES: Both Endotines and Ultratines are made of polymers of polylactic acid and polyglycolic acid and are used in brow elevation procedures. Ultratines appear to be much more likely to break during loading and insertion than Endotines. We report our experience with these devices and offer suggestions to decrease the likelihood of breakage.

METHODS: We retrospectively reviewed all cases of Endotine or Ultratine implantation between December 1, 2003 and April 30, 2009 at the Center for Aesthetic Reconstructive Eyelid and Orbital Surgery (CAREOS) in Austin, TX. The number of devices implanted each year was recorded. Additionally, all broken devices were recorded as well as whether the device broke during loading or insertion.

RESULTS: 176 Endotines were inserted in 90 patients (86 bilateral and 4 unilateral) between December 2003 and March 2007. None were reported broken. From April 2007 to April 2009 116 Ultratines were inserted in 60 patients (56 bilateral and 4 unilateral). During this period, 6 were broken and returned to Coapt. The breakdown by year can be seen in the table. Two Ultratines were broken while loading into the inserter. Four Ultratines were broken during implantation. One Ultratine was broken for every 19.5 successfully implanted, while 178 Endotines were implanted successfully without breaking any. A cluster of 4 Ultratines were broken during 2009. Two of these were found to be from a lot with a mislabeled expiration date, though none were expired at the time of implantation. This lot was noted to have an increased number of broken Ultratines according to Coapt, but has not been recalled. Two Ultratines that were implanted in one patient in 2008 required subsequent removal due to painful cyst formation at the site of the Ultratines.

CONCLUSIONS: Based on our data the Ultratine appears to be more delicate than the Endotine; however, we prefer the Ultratine because of its more rapid degradation and disappearance from the surgical site. Several strategies can be employed to reduce the likelihood of breakage of Ultratines including handling the device with extreme care, using larger incisions, and applying pressure perpendicular to the bone during insertion. Although the Ultratine does have the advantage of faster absorption compared to the Endotine, the Ultratine is much more likely to break than the Endotine. Surgeons and their operative staff should be aware of this.

REFERENCES:

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2. Apfelberg DB, Newman J, Graivier M, et al. Multispecialty contralateral study of clinical experience with the Ultratine forehead fixation device: evolution of the original Endotine device. Arch Facial Plast Surg 200810(4):280-2.

3. Berkowitz RL, Apfelberg DB. Preliminary evaluation of a fast-absorbing multipoint fixation device. Aesthet Surg J 200828(5):584-8.

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10:54 am **Browlift Utilizing Self-anchoring, Polypropylene, Barbed Suspension Futures**
CRAIG N. CZYZ, DO

OBJECTIVES: Universal goals of facial surgical aesthetic procedures include minimal risk and persistent results. Suspension sutures with irregular surfaces to grasp and reposition tissue have been proposed as a minimally invasive surgical technique. This study evaluates the use of a self-anchoring, barbed polypropylene suture (Contour Threads™, Surgical Specialties Corp., Reading, PA) as a tool for brow elevation.

METHODS: Prospective study to evaluate the efficacy of barbed suspension sutures in brow re-suspension. Forty patients (36F, 4M), with bilateral brow ptosis participated in the study. Patient ages averaged 55 (range 36-76). Patients were evaluated and photographs taken preoperatively and then again at one week and one, three, six, and nine months postoperatively. An independent observer graded photographs. Brow position at three, six, and nine months were compared to original brow height. Position was rated as either: 1. higher; 2. no change; 3. lower. Unexpected side effects of the procedure were recorded. All patients received 60 units of botulinum toxin type A (Botox®, Allergan, Irvine, CA) one week preoperatively (30U to glabella, 15U per side lateral orbicularis oculi). Each patient received one or two barbed sutures per side. 25 patients received CT 200 series sutures and 15 patients received Articulus 400 sutures. 36 of the 40 patients underwent concurrent upper blepharoplasty.

RESULTS: At the 3 months postoperative evaluation, 32 patients (80%) had higher brow position. Eight patients (20%) had no change. Six months postoperatively, 19 patients (48%) had higher brow position, 20 (50%) had no change, and one (2%) had lower brow position. At nine months, six (15%) had higher brow position, 33 (83%) had no change, and one (2%) had lower brow position.

One patient (2%) had suture abscess, two patients (4%) had migrated sutures, 13 (33%) had pain or tenderness with brow palpation or elevation at three months and six (15%) at six months. No patients reported pain or tenderness at nine months.

CONCLUSIONS: Polypropylene, barbed sutures are not effective in the persistent elevation of brow position. While there were no major complications encountered, the percentage of patients that experienced pain and tenderness at three and six months may be a deterrent.

11:00 am **Panel Discussion – Managing Difficult Problems in Facial Cosmetic Surgery**

Moderator: MARC S. COHEN, MD

11:30 am **Adipose-derived Stem Cell Therapies in Plastic Surgery Research**

KACEY MARRA, PHD
FEATURED SPEAKER

OBJECTIVES: The potential of adipose-derived stem cell therapies in plastic surgery will be discussed.

METHODS: Our laboratory conducts research in biomaterials, drug delivery, and adult stem cell biology for various regenerative medicine applications. The potential applications of adult stem cells derived from discarded adipose tissue are immense. We have been harvesting and characterizing human adipose-derived stem cells (ASCs) for the past seven years. Our objectives are to utilize ASCs in tissue engineering applications such as bone, nerve, soft tissue, and cartilage regeneration, as well as develop novel, biodegradable substrates for ASCs. We have isolated and characterized ASCs from over one hundred healthy patients, and we have differentiated the adult stem cells into various phenotypes using different biochemical reagents as well as mechanical forces. We have seeded the cells onto various surface-modified, biodegradable scaffolds in an attempt to form fat, bone, nerve and cartilage.

RESULTS: Current research in our laboratory will be described, including the analysis of injectable biomaterials combined with human adipose-derived stem cells in a mouse model of soft tissue regeneration. Pre-clinical and clinical studies using adipose-derived stem cells will also be reviewed.

CONCLUSIONS: Use of adipose-derived stem cells is quickly becoming a clinical reality. Recent clinical studies abroad are promising, and the potential of these stem cells for soft tissue repair, cartilage regeneration and nerve repair will be discussed.

NOTES

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

1:30 – 3:30 pm **General Session 103: Facial Cosmetic Surgery**

Moderators: STEVEN B. HOPPING, MD AND H. GEORGE BRENNAN, MD

1:30 pm **Minimal Invasive Facial Surgery: History and Evolution**
ZIYA SAYLAN, MD

OBJECTIVES: About 80 years ago Dr. Passot and Dr. Joseph 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 Facelift" with lateral SMASectomy.

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.

Since first performing facelifts 80 years ago surgeons have improved this technique and performing their facelifts differently compared to the early cases. This presentation will emphasize the improvement of minimally invasive techniques also developed and utilized successfully by the author over the past twelve years. The main differences compared to the pioneers are: Less undermining, shorter incisions with less complications and shorter recovery time.

RESULTS: Patients are requesting surgical interventions at earlier ages than ever before. They are interested in maintaining a fresh, youthful appearance but reject the traditional facelift and more invasive procedures designed principally for "restorative" facial rejuvenation in older patients. This presentation will emphasize minimally invasive techniques developed and utilized successfully by the surgeons over the past 15 years. The proper combination of less invasive procedures in such patients can provide results equal to more traditional techniques often with less scarring, short recovery time and more natural results. Part of the

aging process is gravity but much of aging is atrophy. This presentation will also discuss minimally invasive techniques for both "filling" and "lifting" the aging face to achieve superior, less operated looking results.

CONCLUSIONS: The minimal invasive facelifts are safe, quick and simple procedures 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 conventional facelifts.

NOTES

1:40 pm **External Application of Low-level Laser at 635nm for Non-invasive Body Contouring: A Randomized, Controlled Study**
RYAN MALONEY

OBJECTIVE: A great demand exists amongst cosmetic patients for a reliable, safe, and now more than ever non-invasive technique for body contouring. Early histological work examining adipocytes exposed to low-level laser irradiation at 635nm has revealed their collapse based on the formation of an aperture in the protective membrane immediately following light irradiation. Such work warranted this institutional review board study to evaluate the efficacy and safety of an external 635nm 17.5mW exist power diode laser device for non-invasive circumferential reduction of the waist, hip, and thighs.

METHODS: Sixty-seven volunteers between the ages 18 to 65 with a Body Mass Index between 25 kg/m^2 and 30 kg/m^2 and who satisfied the set inclusion criteria were enrolled in a double-blind, randomized, placebo-controlled, multi-site clinical trial. Participants were treated for two consecutive weeks receiving three treatments per week. The waist, hip, and thighs were treated simultaneously for 20 minutes along the anterior aspect and for 20 minutes along the posterior aspect. Patients were evaluated at 4 periods: pre-procedure, week 1, week 2, and 2 weeks post-procedure.

RESULTS: Compared with baseline, the total combined circumference measurements for test subjects were significantly lower at all three subsequent evaluation points: -2.06 inches at week 1 ($p<0.01$), -3.52 inches at week 2 ($p<0.01$), and -3.21 inches at 2 weeks post-procedure ($p<0.01$). Compared with baseline, participants of the test group demonstrated an overall reduction in circumference measurements at the week 2 evaluation point of -0.98 inches across the waist ($p<0.0001$), -1.05 inches for the hip ($p<0.01$), -0.85 inches for the right thigh ($p<0.01$), and -0.65 inches for left thigh ($p<0.01$). Compared with baseline, the changes in total circumference measurements between groups were statistically significant at all three subsequent evaluation points: -1.794 inches at week 1 ($p<0.0005$), -2.838 inches at week 2 ($p<0.0001$), and -2.593 inches at 2 weeks post-procedure ($p<0.0001$).

CONCLUSION: These data suggest that low-level laser therapy can promote circumferential reduction (in inches) of the waist, hip, and thighs.

1:50 pm **Double-layered, Running, Locking SMAS Plication in Short-Scar Rhytidectomy: Biomechanics Research as Applied to Cosmetic Surgery**
JEREMY B. WHITE, MD

OBJECTIVES: To assess complication rates in short-scar rhytidectomy using a double-layered, running, locking SMAS plication technique. Pertinent suture biomechanics research will also be reviewed to discuss the transition from basic science to clinical studies.

METHODS: A retrospective review of 2300 patients undergoing short-scar rhytidectomy over an 84-month period was conducted. SMAS plication was accomplished with the double-layered, running, locking (DRL) technique in all patients. Charts were reviewed for post-operative complications after a minimum of six months. Complication rates were compared to those from a previous cohort of 1000 short-scar rhytidectomies in which SMAS plications were accomplished with several other suture techniques.

RESULTS: After at least 6 months, 537 patients (23.3%) experienced suture extrusions. Other complications included hematoma formation (0.7%), postauricular nodules (0.65%), hypertrophic scarring (0.39%), hyperpigmentation (0.17%), infection (0.04%) and need for touch-up liposuction (0.78%). Revision rhytidectomy was required in only 7 patients (0.3%). Skin and subcutaneous suture extrusion rates were significantly higher in the group undergoing DRL SMAS plication ($P<0.001$), but there was no difference in the rate of plication suture extrusion. Other complication rates were not significantly different between groups.

CONCLUSIONS: Use of the DRL stitch technique for SMAS plication in short-scar rhytidectomy is associated with very low revision rates after at least 6 months of follow-up. Comparisons with other commonly used techniques should be conducted after longer follow-up periods in order to determine if there are long-term differences that can be attributed to this suture technique. With respect to short-term differences during scar formation, however, there does not appear to be a significant difference in the need for early revision rhytidectomy between the use of the DRL stitch and any other suture technique. It is possible that this suture technique may have more benefit for procedures in which the soft tissues must withstand greater biomechanical stress, such as in abdominoplasty, and this should be evaluated in future clinical studies.

NOTES

1:55 pm **Double "C" Plication**
KEVIN SADATI, DO

OBJECTIVE: Facial rejuvenation procedures have evolved significantly since they were first performed at the beginning of the 20th century. Modern SMAS lifting techniques focus on providing natural facial rejuvenation, durable results, fewer complications, and reduced morbidity. Many techniques exist, each proposing different methods to attain a common goal, resuspension of the SMAS. Introduction of a simple new technique for SMAS plication of lower face and neck called Reverse "C" Lift. This technique is reproducible and simple, resulting in a natural look with low complication rate.

METHODS: In over 1500 facelifts in the last 4 years, the author has evolved a simple technique with a natural look. All cases were done with oral sedation and local anesthesia. Patients were ambulatory immediately following surgery and had a rapid recovery with little edema or ecchymosis. Nerve injuries were avoided, and the temple hairline and earlobe clefts were preserved. There are no ridges, dimples, or ''joker lines." Revision rate was less than 0.7%. This technique utilizes a double running plication suture for SMAS suspension, which can be placed via traditional or short-scar facelift incisions. This technique provides for an evenly distributed radial traction on the SMAS and lateral platysma, allowing for a more uniform suspension compared to traditional single plication sutures which only provide point specific tension. This technique laces the face up just like lacing a shoe, making the entire face firm and youthful and the neck plication pulls the tissues up behind the ear and a platysmal sling keeps the earlobe up in its normal position.

RESULTS: Over a 4-year period (2005-2009), 1532 procedures were performed utilizing the aforementioned RCL technique. The maximum follow-up period has been 36 months and the minimum 6 months. This is a retrospective chart review of a single surgeon's rhytidectomy practice. Of the 1532 patients, 110 had undergone previous rhytidectomy by a different surgeon. Complications included in the evaluation process were major hematoma 1.3%, minor hematoma 5%, infection 0.5%, facial nerve injury 0%, greater auricular nerve injury 0.1%, post auricular skin necrosis (>2cm) 0.8%, and revision rate 0.7%.

CONCLUSION: The Double "C" Lift, RCL, is a reliable, simple, and reproducible technique with natural results and low complications. This technique involves a double running plication suturing of SMAS and lateral platysmal in a double "C" Shape pattern.

2:00 pm **New Paradigms in Facelift Surgery: The Laser Facelift**
PATRICK G. MCMENAMIN, MD

OBJECTIVES: Fourth generation laser lipolysis technology uses light and heat energy subcutaneously to provide skin and tissue tightening in the face. Following DiBernardo's work on uniform application of energy to create measurable skin temperature elevations (38-41°C), we have developed 4 major categories for performing laser facelifts. These include revision facelifts, younger vs. more mature patients, and heavy neck patients with very limited open mini SMAS tightening techniques.

Our preliminary work was presented in ***Cosmetic Surgery Times*** in April 2009 and my initial lecture was at Johns Hopkins Hospital Department of Otolaryngology/ Head and Neck Surgery in June 2009. This will be an update of our work with specific recommendations on the procedure, anesthesia, energy levels, and hopefully, tissue harvest to document the laser effects.

METHODS: The first year we performed 25 laser facelifts using tumescent anesthesia and oral sedation only. We extend past the nasolabial line and aggressively address the jowl, oral commissure, and the lateral lips. Our closed laser technique has surpassed our open procedures in these areas.

RESULTS: We have had no burns or major complications. There have been no injuries to the facial nerve. All of our patients (except the open SMAS category) have returned to work and social events within 1 week (many within 2-3 days). Somewhat normal sensation has returned in 7-10 days.

CONCLUSIONS: Our preliminary work was presented in ***Cosmetic Surgery Times*** in April 2009 and my initial lecture was at Johns Hopkins Hospital Department of Otolaryngology/Head and Neck Surgery in June 2009. This will be an update of our work with specific recommendations on the procedure, anesthesia, energy levels, and hopefully, tissue harvest to document the laser effects.

NOTES

2:10 pm **Placement of Silicone Midface/Cheek Implants During Rhytidectomy Surgery**
RONALD MANCINI, MD

OBJECTIVES: Increasingly, cosmetic facial surgeons have begun to recognize the significant role that soft tissue loss, fat deflation, and facial skeletal boney resorption play in facial aging. This has prompted a shift in facial rejuvenation procedures from pure lifting techniques, to techniques which restore lost volume as well. Midface/cheek implants are typically placed through an intraoral or transconjunctival approach in an attempt to restore this volume. Here we describe our technique for placing silicone midface/cheek implants during rhytidectomy surgery via the facelift flap.

METHODS: A retrospective analysis was performed on patients who underwent placement of silicone midface/cheek implants during rhytidectomy surgery. Implants were custom-trimmed for each patient from a solid silicone sheet, to address individual volume deficiencies. The implants were introduced into the sub-periosteal space overlying the maxillary face and medial aspect of the zygoma during facelift surgery. Access was achieved via a 1cm incision through the subcutaneous soft tissues overlying the body of the zygoma. Pre- and postoperative photos were reviewed, patient satisfaction assessed and postoperative complications reviewed.

RESULTS: A total of 30 patients were identified who underwent silicone implant midface/cheek augmentation during rhytidectomy surgery. 28 of 30 patients were satisfied with the volume enhancement of the cheek region. Two patients requested implant removal due to dissatisfaction with the cosmetic result feeling the implants were too large. One of these patients had the implants trimmed and replaced during a second procedure. The average follow up was 24 months.

CONCLUSIONS: Silicone midface/cheek implants provide a permanent means of volume enhancement and can easily and safely be placed during rhytidectomy surgery via the facelift flap dissection. The advantages to this approach include avoidance of a second surgical site when implants are placed during rhytidectomy, for example an intraoral or transconjunctival approach, and the ability to custom tailor the implant to address the patient's individual volume needs. Avoidance of a second incision site, particularly an intraoral incision, may also reduce the risk of implant infection.

NOTES

2:20 pm **Autologous Fat Transfer as an Adjuvant to Rhytidectomy**
TANUJ NAKRA, MD

OBJECTIVES: Rhytidectomy is an effective tool for improving age-related gravitational changes of the lower face. Rhytidectomy can be used to improve the contour of the midface region as well, however its efficacy in the midface is limited. A more aggressive dissection along branches of the facial nerve is required to release and elevate the midface region. Furthermore, the age-related changes in the midface are largely due to deflation of soft tissue rather than descent. Autologous fat transplantation is a powerful modality for restoring soft tissue volume in the midface and other areas of the face. We present our technique of combining autologous fat transfer with rhytidectomy.

METHODS: A retrospective analysis was performed on patients who underwent autologous fat transfer during rhytidectomy surgery from July 1, 2007 to June 15, 2009. Rhytidectomy was performed by standard extended sub-SMASectomy techniques. Abdominal and lateral thigh fat were used as donor fat harvest sites. Gravitational decanting was used to isolate the fat, and the fat was transferred to 1cc syringes and injected using the Tulip disposable canula system. Fat was transferred to various areas of the face, with the majority injected via the rhytidectomy flap into the midface region. Other areas injected include the forehead, glabella, brow fat pads, tear troughs, malar areas, cheek fat pads, lips, pre-jowl regions, and earlobes bilaterally. Fat was injected into the subcutaneous, SMAS, and pre-periosteal planes. Pre- and postoperative photos were reviewed for efficacy of rejuvenation, particularly in the midface region. Postoperative complications were reviewed.

RESULTS: A total of 54 patients were identified who underwent autologous fat transfer during rhytidectomy in the specified period. The vast majority of patients had notable improvement in the contour of the midface. The surgery time was reduced compared to deep-plane rhytidectomy without autologous fat transfer cases performed around the same time. There were no cases of transient or permanent postoperative facial nerve branch palsy. Pre- and postoperative photographs will be presented to demonstrate the benefits of this combined procedure.

CONCLUSIONS: Autologous fat transfer is a safe and minimally-invasive adjuvant to rhytidectomy surgery that reduces the need for more aggressive midface maneuvers, reduces the total surgical time, and produces a natural-appearing rejuvenation in the midface region. The combination procedure is powerful technique that provides comprehensive contour improvement for the aging face.

2:30 pm **Cosmetic Surgery, The Past, The Present, The Future**

KURT J. WAGNER, MD
FEATURED SPEAKER

Let us define the difference between Reconstructive and Esthetic Surgery for this discussion. Gillies definition: reconstructive = restore to normal; esthetic = surpass the normal evolution.

We will trace the evolution of techniques from Sushruta, an Indian practitioner in 600 BC, through the Renaissance, and the great impetus given by the World Wars with the development of modern anesthetic and surgical techniques, the spread of teaching across the oceans and finding a place in the USA. We will follow the development of centers and the specialization of practices as seen today.

My role in the scheme of things: Why did I become a plastic surgeon? How I came to be at the right place at the right time. I will describe my practice outside the hospital on an office setting which I helped popularize in the late 60s. How the extreme makeover came to be and my struggle to free our contemporaries to use the media to spread the gospel. Could I have started the "Golden Age"?

What Does the Future Hold? Will robotics, endoscopy and stem cell research and the like change our techniques? Are lasers a real alternative to the knife? What is our responsibility to the public and to ourselves in practicing our trade?

3:00 pm **Panel Discussion – Managing Difficult Problems in Facial Cosmetic Surgery**

Moderator: H. GEORGE BRENNAN, 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: Wekiwa 1&2

Surgery of the Aging Face – Evolution of Treatment – Meet the Masters

H. George Brennan, MD and Kurt Wagner, MD

The three participants will each present a personal vilgrette of the evolution of treatment of aging face during their extended career in this field. They each will discuss the techniques and results in their earlier years and will talk about the conceptual and technical evolution of their techniques to their current approach of the aging face. Each participant will limit their discussion as to allow ample time for audience interaction and discussion.

BREAKOUT #2

Location: Wekiwa 3&4

Laser Lipolysis and Skin Tightening

Thomas W. Barnes, MD and Robert H. Burke, MD, DDS

This presentation will review use of two wavelengths: 1064 and 1320. Use of single 1064 wavelength and the dual wave: 1064 nm; 1320 nm for laser lipolysis will be discussed. Safety, outcomes, and complications will be reviewed. Temperature data obtained during clinical treatment will be reviewed and discussed.

Three patient populations will be reviewed: those with minimal lipodysmorphia and little or no skin laxity; those with moderate to severe lipodysmorphia and varying degrees of laxity ranging from moderate to severe; those with volume deficiency and skin-fascial laxity.

The use of laser lipolysis as an adjunct to rhytidectomy and abdominoplasty will also be reviewed.

NOTES

BREAKOUT #3

Location: Wekiwa 5

Eyelid Rejuvenation – 2010

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

The object of this breakout session is to teach the participant how rejuvenate the eyelids with a state-of-the-art blepharoplasty and minimally invasive treatments like fillers and Botox Cosmetic and the non-invasive treatment, Latisse.

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, Botox and Latisse. The course will employ extensive clinical examples to help the participants understand the important principles of eyelid rejuvenation. This is a substantially updated version of a breakout session given last year. We believe that this presentation will be of value to the beginning, moderate and advanced blepharoplasty surgeon.

BREAKOUT #4

Location: Wekiwa 7&8

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 breast 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. There has been much press about a so-called 'mommy makeover' which often involves breast augmentation with mastopexy in addition to a possible abdominoplasty. An isolated mastopexy to treat the sagging breast or basic augmentation with implants may be relatively straightforward in select patients; however, combining mastopexy with implants during the same surgery can be challenging for the most experienced surgeons. 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 discussed along with ways to help avoid common complications. Treatment of difficult cases and revision surgery will also be reviewed.

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BREAKOUT #5 FACIAL COSMETIC SURGERY

Location: General Session – Gatlin C

Moderators: MOHAN THOMAS, MD AND ROBERT M. SCHWARCZ, MD

4:00 pm **Improve Your Facelift Results – Using a Combination of Minimal Surgical Techniques and Technologies will Maximize Facial Rejuvenation Results for Your Patients**
ZIYA SAYLAN, MD

Patients are interested in maintaining a fresh, youthful appearance but reject the traditional facelift and more invasive procedures designed principally for "restorative" facial rejuvenation in older patients. This presentation will emphasize minimally invasive techniques developed and utilized successfully by the author over the past ten years. The proper combination of less invasive procedures and modern technologies in such patients can provide results equal to more traditional techniques often with less scarring, short recovery time and more natural results. Part of the aging process is gravity but much of aging is atrophy. For that reason minimally invasive and non-surgical techniques together will achieve natural looking and less operated looking results.

Facelift of 2009 is a combination of:

1. Minimal incision facelift; fixation of the SMAS to the Zygoma
2. Posterior Neck Lift with or without GoreTex Neck Sling
3. Serial Platysma Notching
4. Buccal Fat Extraction
5. Temporal Lift (T-Lift)
6. Lower Lid Suspension with a Muscle Sling
7. Chin and cheek augmentation also with stem cell enriched fat grafts
8. Skin rejuvenation with fractional lasers or chemical peelings

Minimal Incision Facelift or S-Lift are procedures where the soft tissue (SMAS and ESP) is plicated and fixed to the periosteum of the zygomatic bone, a deep dissection is not necessary. The suspension achieved is much more stable compared to conventional facelifts. The S-Lift is a safe, quick and a simple procedure with effective results suitable for younger patients with very satisfactory aesthetic results. Complication rates and

recovery times are low. The procedure limits scarring and gives a more natural look than standard facelifts.

This presentation will emphasize the S-Lift and the use of the purse string plication of the SMAS and extended S-Lift procedures including S-Lift with SMASectomy for the midface.

The incisions for the posterior neck lift are behind the ears, on the hairline. The neck muscles and the skin are pulled separately. The Platysma and the fascia are pulled and sutured to the mastoid bone. This will not improve the skin condition of the anterior neck so that fractional laser and radiofrequency is required to improve the skin.

Treatment of the aging neck with posterior neck lift technique, ePTFE neck sling and serial platysma notching for banding will be presented.

Techniques of profiloplasty including cervical liposuction, buccal fat extraction, and chin augmentation for rejuvenation of the neck will be discussed.

The traditional midline suturing was not that satisfactory and with our patients a revision and scar correction in 14% of the cases were necessary. Most of the patients spoke about a persisting.

Hardened tissue at submental region after the platysmaplasty. The patients here show platysma bands so that a marking can be made with a distance of 3-4 cm between every incision. The Serial Platysma Notching is done with an electrocauthery and repeated many times along the muscle.

NOTES

4:08 pm **The Split SMAS Transposition Flap**
ROBERT M. SCHWARCZ, MD

OBJECTIVES: To discuss an evolution of the lateral SMASectomy, by splitting the lower SMAS and rotating it posteriorly with the jawline.

METHODS: After a skin flap is created and extended medially into the malar region stopping a few centimeters short of the nasolabial fold, the SMAS is marked diagonally just lateral to the lateral canthus to the inferior most aspect of the ear lobule. This marking is parallel with the nasolabial fold as described by Baker in the Lateral SMASectomy. Using a 15 blade a sub-SMAS dissection is carried out medially keeping the dissection superficial to the deep fascia. At the lower two-thirds, one-third junction the dissected SMAS is incised, splitting the lower third of smas in the direction of the chin. The upper two-thirds of SMAS flap is elevated in a superlateral vector with the redundant portion excised and the remaining flap sutured to stable SMAS posteriorly with buried interrupted 4-0 Mersilene. The lower one third SMAS is rotated in line with the angle of the mandible securing it to the Mastoid fascia with a 4-0 Merseline in a buried mattress fashion, the redundant SMAS is excised just under the ear. This procedure is usually performed in conjunction with an anterior platysmal corset platysmaplasty.

RESULTS: A redefined jawline with reliable correction of jowls and rejuvenation of the face is accomplished precluding the need for lateral platysmaplasty when performed in conjunction with a corset anterior platysmaplasty along with a modest midface correction.

CONCLUSIONS: In following the progression of the SMAS facelift that started with Mitz and Peyronie, beginning with the extended SMASectomy described by Baker the Split SMAS rotation flap is a natural progression of the procedure incorporating both a superolateral vector for the upper portion of the SMAS flap and lateral vector for the lower in line with the angle of the mandible. This avoids some of the windswept deformities noted around the mouth and allows for a more anatomical lower facelift incorporating the jawline in the SMAS flap and not leaving that only to the posterior platysmal flap. This technique done in conjunction with the anterior corset platysmaplasty described by Feldman in the correctly chosen patient could eliminate the need for a posterior platysmaplasty and allows for the lower SMAS to be involved with redefining the jawline.

NOTES

4:16 pm **Mini Vertical Pull Face Lift (MVP Face Lift): An Introduction of A New Technique**
WAEL KOULI, MD

INTRODUCTION: Maintaining a natural appearance and limiting the sequelae of a face lift have always been major goals for us. Limitation of scar visibility and avoidance of hairline displacement are fundamental, especially for younger patients. Patients are asking for short recovery periods after facial rejuvenation surgery, with a lower possibility of potential complications or increased surgical risk.

MATERIAL & METHOD: Based on the above-mentioned philosophies, we are presenting the Mini Vertical Pull Face Lift (MVP Face Lift). This procedure will combine a limited SMAS dissection with a critical vertical vector of the SMAS repair to the Zygoma. This is done with short preauricular incisions and sideburn flap creation to minimize dog-ear appearance and sideburn elevation.

RESULTS: All of our ten patients recovered well from the surgery described. None of the patients developed any post-operative complications. One year follow up were consistent with our expectations: minimal facial scar, no sideburn elevation, dog-ear deformity, or earlobe deformity. Our patients has expressed very good satisfaction and significant improvement of their lower facial drop.

CONCLUSION: The advantages of a MVP lift compared with classical lifting techniques are a quick procedure, local or sedation anesthesia, no hospital admission, a short recovery period, and an inconspicuous, short scar without raising of the temporal or occipital hairline and avoidance of a standing cone ("dog ear") appearance in the temporal region. Perhaps most importantly, it is a safe procedure.

NOTES

4:24 pm **Corset Platysmaplasty in the Management of the Aging Neck**
L. MIKE NAYAK, MD

OBJECTIVES: To review the anatomy of the aging neck and to review both superficial and deep cervicoplasty techniques.

METHODS: The relevant surgical anatomy of the neck will be reviewed. Superficial treatments, such as skin flap undermining and extraplatysmal lipectomy will be addressed, as well deep cervicoplasty techniques addressing the subplatysmal fact and suprahyoid musculature. Limited anterior platysmarraphy will be reviewed, as will the Feldman multilayer full-length plastymaplasty. Technical points will be made by use of diagrams and intraoperative photos and videos. Pearls and pitfalls of advanced cervicoplasty will be reviewed.

RESULTS: Expected results, limitations, and selected complications will be demonstrated by means of controlled before and after photographs.

CONCLUSIONS: Management of the aging neck depends on a thorough understanding of its lamellar anatomy. By addressing the lamella appropriately, dramatic and long-lasting results in the submental and submandibular neck may be achieved.

4:32 pm **Isolated Cervicoplasty of the Neck: Pearls and Pitfalls**
TIRBOD FATTAHI, MD, DDS

OBJECTIVES: To evaluate the benefits of isolated cervicoplasty of the neck in lower facial rejuvenation following the current guidelines as described and later modified by Joel Feldman. The purpose of this presentation is to familiarize the audience with one surgeon's experience in performing isolated cervicoplasty for patients desiring rejuvenation of the lower face and neck.

METHODS: A retrospective chart review of all patients who underwent an isolated cervicoplasty of the neck without a concomitant face lift was performed. Pre-operative findings, patient selection guidelines, surgical maneuvers, and any post-operative complication were then recorded and secondarily evaluated. "Pearls and pitfalls" were then determined in order to improve surgical outcome in future cases.

RESULTS: As long as specific surgical techniques are used, such as open liposuction, anterior platysmaplasty (submentoplasty), and preservation of the sub-platysmal fat, predictable and aesthetic results can be obtained following isolated cervicoplasty of the neck.

CONCLUSION: Isolated cervicoplasty can be a rewarding cosmetic procedure in the rejuvenation of the anterior neck as long as specific surgical principles are followed. Improvements in the cervico-mental region and anterior neck in profile can be significant and quite pleasing.

NOTES

4:40 pm **Increased Incidence of Body Dysmorphic Disorder in Adult Patients Seeking Facial Cosmetic But Not Orthognathic Surgery from Oral and Maxillofacial Surgeons**

MICHAEL HORAN, MD, DDS, PHD

OBJECTIVES: Oral and Maxillofacial Surgeons aid orthodontists in the alignment of teeth by performing orthognathic surgery to correct misalignment of the jaws due to dentofacial deformities. These procedures significantly impact the patients' appearance, often improving the patients' facial profile and symmetry. No assessment tool is currently in place to screen patients seeking orthognathic surgery for BDD. Furthermore, as Oral and Maxillofacial Surgeons expand the scope of their practice to include more cosmetic facial surgery, it will be important to screen this population of patients in order to identify individuals that have BDD. The purpose of the present study was to identify adult patients with BDD seeking facial cosmetic or orthognathic surgery procedures by utilizing a well documented, "user friendly" BDD screening tool, the BDD Questionnaire (BDDQ) (Dufresne et al, 2001).

METHODS: The current study was designed as a cross-sectional cohort study consisting of three groups: 1) patients seeking facial cosmetic surgery, 2) patients seeking orthognathic surgery, and 3) patients seeking dentoalveolar surgery. Each potential patient participant received information describing the study. If interested, the patient was consented. Patients were then administered the BDDQ at the initial consultation appointment. 46 patients, 18 years of age or older, seeking care in the department of Oral and Maxillofacial Surgery at the Case Western Reverve University School of Dental Medicine were enrolled in the study. Of the 46 patients enrolled, 5 were unable to complete the BDDQ due to time constraints. Of the 41 patients that completed the BDDQ, 4 patients presented for orthognathic, 12 patients for cosmetic, and 25 patients for dentoalveolar consultations. The mean BDDQ score was calculated for each group and data was presented as mean ± standard error. Intergroup differences were analyzed using ANOVA and Tukey-Kramer post-hoc analysis. Data analysis were performed on NCSS/PASS '04 for Windows XP. Approval for the study was obtained from the Case Western Reserve University Institutional Review Board for Social and Behavioral Science (IRB#20080104).

RESULTS: BDDQ revealed a mean score of 1.833 (±0.197), 1.250 (±0.342), and 1.160 (±0.136) for patients presenting for cosmetic, orthognathic, and dentoalveolar surgery consultations, respectively. A significant difference was noted between patients seeking facial cosmetic and those seeking dentoalveolar surgery (P0.05). Patients with previously diagnosed psychiatric conditions tended to score higher on the BDDQ. Interestingly, only one patient scored above the BDDQ threshold for clinical suspicion of BDD, and that patient was seeking dentoalveolar surgery.

CONCLUSIONS: This study indicate that patients seeking facial cosmetic surgery from Oral and Maxillofacial Surgeons score significantly higher on the BDDQ than do patients seeking dentoalveolar surgery, whereas those seeking orthognathic surgery do not. The BDDQ is a fast and efficient way to screen patients seeking either orthognathic or facial cosmetic surgery for BDD.

4:48 pm **Rhytidectomy Incision Designs in Relationship with the Vector of Skin Redraping and Volumetric Changes of the Skin by Means of a 3D Finite Element Model of the Ageing Skin**
NATALIE A. LOOMANS, MD

OBJECTIVES: Dog-ear deformities are recognized as problems associated with the design of the peri-auricular incision and vector of pull in facelifting.

Prevention of these undesirable results and beautifying of the peri-auricular area is the surgical challenge. A literature review analyses the different incision designs in the temporal, pre-auricular and retro-auricular region. Skin tension vectors are related to incision designs.

The aim of the study is to define the peri-auricular problems by means of a 3-dimensional finite element model of the ageing skin, and to recommend an effective approach related to skin type, hairline, and vector.

METHODS: The objective of the calculated response of facial tissues to the application of pressure or traction is to qualitatively verify the prediction of the finite element model with respect to ageing, as described by the theory of gravimetric descent. Knowing the elastic and viscoplastic behavior of the skin due to ageing, volumetric changes according to the vector of movement which is different in the facelift incisions can be recorded.

RESULTS: Mainly the rhytidectomy incision designs can be divided in 2 major groups.

One group with a mainly vertical vector and one with a larger horizontal component.

According to the main vector, vertical or horizontal, volumetric excess can be predicted respectively in the sideburn area or in the earlobule region and the retroauricular zone.

Tissue excess on this turn can predict hairline deformity in these regions.

CONCLUSIONS: Prediction of volumetric changes with the finite element model of the skin allows us to choose a main vector of traction according to skin type and age.

According to the chosen vector several facelift incisions can be proposed.

4:56 pm **Purse String Facelifting**
L. MIKE NAYAK, MD

OBJECTIVES: Describe, through diagrams and intraoperative photos, a safe, straightforward, and powerful procedure that lifts the lower face and neck through anchored purse string SMAS/platysmal plication.

METHODS: The procedure described is readily performed under light oral or intravenous sedation plus superwet or tumescent local anesthesia. Step-by-step photographs and descriptions of preoperative marking, local anesthesia, manual syringe liposuction, skin flap elevation, purse string SMAS plication, and flap redraping and inset will be shown.

RESULTS: Several representative before and after results, at one week, one month and one year postop, will be reviewed in order to demonstrate the procedures expected benefits and limitations.

CONCLUSIONS: Purse string facelifting is a safe, simple, and effective means of rejuvenating the moderately aged lower face and neck under very light to moderate sedation. Results compare favorably, both in scope and longevity, to more invasive facelifting procedures.

5:04 pm **The High Quadrilateral SMAS Flap – A Versatile Technique in Facial Rejuvenation**
MOHAN THOMAS, MD

OBJECTIVES: Techniques for rhytidectomy/face lift are evolving. The key objectives in face lift surgery should be a natural looking and stable rejuvenation. Many of the minimally invasive procedures fall short in this regard. The author's experience with 60 cases of high quadrilateral SMAS flap rhytidectomy is presented.

METHODS: 60 cases of facial rhytides were treated using the high quadrilateral SMAS flap technique. Elevation of the SMAS as a flap with a back cut just below the zygomatic arch increases the mobility of the tissues of the mid and lower face. The SMAS flap is pulled along predetermined vectors as decided preoperatively and sutured. Skin excess is removed and skin is draped over the SMAS and closed. Patients were followed up for maximum of 4 years and average of 2 years.

RESULTS: The aesthetic outcome was excellent in all cases. The effect of surgery was maintained even in the long term follow ups and did not require any touch up. Patients were particularly pleased with the natural look without any lateral sweep. Neuropraxia of buccal branch of facial nerve was seen in 2 cases which recovered within 3 weeks.

CONCLUSIONS: A high quadrilateral SMAS flap technique produces powerful and natural looking rejuvenation of the face which remains stable in the long term. Complication rates are very low. The technique needs to be adopted on a wider scale for better patient satisfaction.

5:12 pm **Custom Silicone Nasolabial Implants Placed Through an Intranasal Approach**
RONALD MANCINI, MD

OBJECTIVES: A prominent nasolabial fold is associated with age-related mid-facial soft tissue deflation, and significantly contributes to the aged face. Various techniques have been described to efface the nasolabial fold ranging from surgical redistribution of mid-facial soft tissue to direct injectable filling. We describe a novel silicone implant placed through an intranasal approach designed to soften the nasolabial fold.

METHODS: A retrospective analysis was performed on patients who underwent placement of custom silicone nasolabial implants. Implants were custom-trimmed for each patient from solid silicone sheets, and were introduced into the pre-periosteal space in the sub-nasolabial fold region via a nasal mucosal incision in the base of the ala. Two implant sizes we fashioned and utilized depending on the severity of the fold: a 3mm thick implant and a 5mm thick implant. The smaller 3mm thick implant displaces 0.5cc of water and the larger 5mm thick implant displaces 1cc of water. Pre- and postoperative photos were reviewed for efficacy of nasolabial fold effacement. Postoperative complications were reviewed.

RESULTS: A total of 100 patients were identified who underwent sub-nasolabial fold augmentation. 65% of patients (65 patients) had marked improvement of the nasolabial fold; 30% of patients (30 patients) had moderate improvement of the nasolabial fold; 5% of patients (5 patients) had minimal improvement of the nasolabial fold. No patient requested implant removal; however, one case of implant infection was noted which required implant removal. The average follow up was 3 years.

CONCLUSIONS: Augmentation of the sub-nasolabial fold area with solid silicone implants is a safe and effective procedure for effacement of the nasolabial fold, providing a rapid and inexpensive option for addressing this area.

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5:20 pm **Malar Edema: An Adverse Event Following Cheek Augmentation with Dermal Fillers**
DAVID FUNT, MD

As dermal fillers have evolved, volume restoration and contour enhancement have become the objective of advanced injectors. The value of injections of dermal fillers into the midface is well documented in the literature. However, the midface is the facial area most prone to adverse events from facial filler treatment. Malar edema is a particularly significant and long-lasting untoward event which is not infrequently reported. This presentation reviews the anatomic basis for malar edema, relates it to filler injections technique, and presents the author's preferred method of injections. It includes representative photographs of patients treated for volume restoration and contour enhancement.

5:28 pm **An Integrative Approach to Cosmetic Surgery and Rejuvenation Medicine**
LEONARD A. RUBINSTEIN, MD

OBJECTIVES: An integrative approach to Cosmetic Surgery and Rejuvenation Medicine has been developed over 25 years which includes components of Allopathic, Homeopathic, Oriental and Ayurvedic Medicine for optimal results.

METHODS: Patients presenting to our offices are comprehensively evaluated and encouraged to participate in several proposed diagnostic and therapeutic components which include modalities from various medical schools of thought.

RESULTS: The integration of the care provided to our patients in a comprehensive and holistic manner, paying attention not only to cosmetic image-enhancement procedures but also to the underlying functional state of the patients' overall well-being has led to optimal treatment results.

CONCLUSIONS: The integrative and holistic approach to image enhancement and rejuvenation has maximized longevity of treatment results, minimized peri-operative discomfort and bruising and has enhanced patient satisfaction.

5:36 pm **Sessions Adjourn**

5:30 – 6:30 pm **Welcome Reception in Exhibit Hall**

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FRIDAY, JANUARY 29, 2010

THE ART OF COSMETIC BODY SURGERY

SCHEDULE-AT-A-GLANCE

6:30 am – 4:00 pm	**Registration Open**
8:30 am – 4:00 pm	**Exhibits Open**
7:00 am – 8:30 am	**Bright Eye Sessions: 201**
8:30 am – 9:05 am	**Continental Breakfast in Exhibit Hall**
9:05 am – 12:00 pm	**General Session: 202 – Cosmetic Body Surgery**
12:00 pm – 1:30 pm	**Lunch in Exhibit Hall**
1:30 pm – 3:30 pm	**General Session: 203 – Cosmetic Body Surgery**
3:30 pm – 4:00 pm	**Coffee Break in Exhibit Hall**
4:00 pm – 5:30 pm	**Cosmetic Surgery Essentials: 204**
5:30 pm	**Sessions Adjourn**
7:00 pm	**Webster Society and Cosmetic Surgery Foundation Gala Dinner**

FRIDAY, JANUARY 29, 2010

7:00 – 8:30 am BRIGHT EYE SESSIONS: 201
(Sessions will run concurrently)

BREAKOUT #1

Location: Wekiwa 1&2

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 the beginner TUBA surgeon who has a solid background in breast augmentation procedures and the advanced cosmetic breast surgeons who have an interest in adding the TUBA technique to their repertoire of approaches to breast implant surgery. We will show proper and safe techniques for TUBA and some of our early successes and failures. There will be an emphasis on safety and on how to avoid complications in our didactic lectures. Live videos will be shown followed by a question and answer session. The open forum approach will be stressed in order to obtain plenty of audience participation. There will be many before and after photos to evaluate the TUBA method vis-à-vis other augmentation approaches. Both beginner and advanced cosmetic breast surgeons will find the breakout session most fascinating and interactive!

BREAKOUT #2

Location: Wekiwa 3&4

Advanced Chemical Peeling

Suzan Obagi, MD and Rebecca Tung, MD

Chemical peels continue to be a powerful tool in skin rejuvenation. The ability to combine them with multiple procedures or as a stand alone procedure makes them very useful. This talk will cover medium depth and deep peels in depth. The discussion will center on patient evaluation, skin conditioning, the chemical peel procedure, and the management of complications.

After this course attendees should be able to:

1) Correctly evaluate a patient preoperatively – assess patient's skin types and PHx/ SHx, contraindications to resurfacing.

2) Understand the mechanism by which the various peeling solutions work on the skin.

3) Understand which peels are medium depth and deep based on intra-operative depth signs, peel concentration, and the chemical solution that is used.

4) Explain how peels can be used in conjunction with noninvasive lasers, IPL, radiofrequency devices, and surgical procedures.

5) Identify and manage complications of skin resurfacing.

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BREAKOUT #3

Location: Wekiwa 5

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: Wekiwa 7&8

Advanced Rhinoplasty Techniques

M. Eugene Tardy, MD and Steven B. Hopping, MD

Rhinoplasty remains one of the most satisfying yet challenging procedures for patients and cosmetic surgeons. Understanding the long term effects of maneuvers performed in the operating room are essential tools to successful aesthetic outcomes.

Dr. Gene Tardy is an internationally recognized rhinoplasty expert. He will share his unique wealth of knowledge and experience in this breakout session speaking about "Refinements in Rhinoplasty: Philosophy and Experience over 40 years". This presentation begins with patient selection and preparation for surgery, followed by the operative steps and video clips that illustrate both basic and advanced techniques. The solution to anatomically challenging variants and difficult rhinoplasty cases will be discussed as well.

Principals of revision rhinoplasty will also be reviewed with an emphasis on preventing untoward results by proper preoperative evaluation. Audience interaction is encouraged making this breakout session particularly exciting.

8:30 - 9:05 am Continental Breakfast in Exhibit Hall

9:05 am – 12:00 pm General Session 202: Cosmetic Body Surgery

Moderators: ROBERT F. JACKSON, MD AND CHASBY SACKS, MD

9:05 am **Abdominoplasty: Choosing the Correct Procedure**
CHASBY SACKS, MD

OBJECTIVES: To present a logical approach to different problems in the abdomen and the different procedures used to correct them.

METHODS: With diagrams and photographs different conditions and the procedures to correct them will be briefly discussed with some discussion of perhaps a less well known method of maximally tightening the upper abdominal skin, when the lower abdomen skin is not very loose by manipulating the position of the released umbilical skin while keeping the horizontal scar low.

RESULTS: A cohesive method to deal with the variations in abdominoplasty is presented.

CONCLUSIONS: Different degrees of skin laxity and fat content in different areas of the abdomen require a logical approach to their correction. Successful results require many different methods – one such collection of methods based on 30 years of experience is presented.

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9:15 am **Abdominoplasty Today**
ROBERT A. SHUMWAY, MD

OBJECTIVES: This retrospective study evaluates various abdominoplasty procedures performed by the author and explains why specific procedures are most suitable for selected patients.

METHODS: A chart investigation comprising the past twenty years of 1000 consecutive abdominoplasty surgeries performed by the author was studied. These surgical procedures were cataloged into one of the five following groups: (1) Mini Tummy Tuck, (2) Lower Abdominoplasty, (3) Avelar Abdominoplasty, (4) Extended Abdominoplasty, and (5) Full Abdominoplasty. The Matarasso Abdominoplasty Classification System (Types I-IV) were utilized to help evaluate patient skin, fat, and their musculofacial anatomy. Relevant treatment plans were accessed according to appropriate clinical conditions, results, and photographs.

RESULTS: The investigator performed 389 mini-tucks, 182 lower abdominoplasties, 93 Avelar procedures, 177 extended tucks, and 159 standard full abdominoplasties upon review. The mini-tucks were most appropriate when only moderate excess skin was an issue, usually after liposuction. The lower abdominoplasty was effective for Matarasso Type II flaccidity of the lower abdominal musculofacial system. The Avelar Tuck was excellent for extensive skin laxity without abdominal wall laxity. The extended or modified abdominoplasty was useful for Matarasso Type III abdomens. Type IV bellies needed a standard, full abdominoplasty for severe skin laxity, extensive abdominal fat, and pronounced upper and lower abdominal muscle flaccidity.

CONCLUSIONS: By thoughtful classification of cosmetic surgery patients into well defined subgroups, who present for abdominoplasty, surgeons can best ensure that the "correct type" of abdominoplasty will be performed for any given patient.

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9:25 am **A Randomized Controlled Trial of the PEAK PlasmaBlade vs. Scalpel and Traditional Electrosurgery in Abdominoplasty**

HOWARD L. ROSENBERG, MD

INTRODUCTION: Traditional electrosurgery is associated with significant thermal injury to surrounding tissue during cutting and coagulation. This thermal necrosis has been shown previously to negatively affect wound healing and post-operative course. We present the results of a prospective, randomized, controlled study examining wound healing characteristics and clinical outcomes following abdominoplasty with the PEAK PlasmaBlade compared to the standard of care. The PlasmaBlade is a new tissue dissection instrument that uses pulsed radiofrequency energy with a highly insulated hand piece to create a precision cutting edge with minimal thermal injury and simultaneous hemostasis.

MATERIALS & METHODS: Twenty patients were randomized to either the Standard of Care (SOC) – scalpel (SC) and traditional electrosurgery (ES) – or the PlasmaBlade (PB) for abdominoplasty. At 6 and 3 weeks prior to surgery, full-thickness skin incisions with SC (#10 Blade), ES (Cut mode, 30W), and PB (Cut 3) were made in the patient's abdomen and closed in a running fashion. Sutures were removed after seven days and incisions were monitored for healing and scar quality. Following abdominoplasty, healed incisions were submitted for burst strength testing and histological analysis. Serous drainage, narcotic consumption, activity level, diet volume, and blood loss were blindly assessed for 10 days following surgery.

RESULTS: PB incisions demonstrated equivalent burst strength to scalpel at 3 (43.44±26.65 lbf/in vs. 43.14±24.39 lbf/in; p=0.95) and 6 weeks (59.32±37.53 lbf/in vs. 51.99±30.38 lbf/in p=0.25) with 65% and 42% greater strength than ES incisions, respectively (26.28±14.42 lbf/in and 41.78±21.71 lbf/in; p<0.005). Histological analysis demonstrated PB incisions reduced thermal injury depth by 74% compared to ES (195±127μm vs. 763±208μm; p<0.005), and exhibited 75% and 95% lower CD3 and CD68 inflammatory cell counts compared to ES, respectively (p < 0.005).

Intra-operatively through discharge to home, PB patients demonstrated 37% less narcotic consumption compared to SOC (32.0±11.2mg vs. 50.7±12.9mg Morphine Sulfate IV equivalent; p=0.002) with equivalent operative time (99±12 min vs.95±9 min, p=0.47). Post-operatively, PB patients demonstrated 49% less narcotic consumption compared to SOC through a 10 day monitoring period (Mean AUC 34.3±10.8 vs. 67.4±38.7; p=0.024). Serous drain output was 31% less in the PB group (Mean AUC 553.4±159.8; SOC 805.3±258.0; p=0.02). PB patients reached 80% of normal diet volume by post-operative day (POD) 6 (SOC>10 days; p=0.02) demonstrating a 35% improvement over SOC (Mean AUC 665.5±162.1

vs. 435.0±230.9; p=0.02). PB patients averaged 10% of normal activity on POD 0 (SOC=2%; p = 0.04) with greater than 50% of their normal activity level by POD 5 (SOC>10 days; p=0.09). Post-operative hemoglobin drop was 57% less for PB at POD 10 (0.7±0.3g vs. 1.6±0.4g; p=0.07). Skin scar width and quality were equivalent for SC and PB at 2 months following surgery (p=0.98).

CONCLUSION: Despite a small study size, results indicate that the PlasmaBlade offers several significant advantages over the standard of care in abdominoplasty and that this device may have great potential in plastic and reconstructive surgery.

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9:35 am **Aesthetic Oncology of the Breast**
MICHAEL H. ROSENBERG, MD

As our ability to diagnose breast cancer at earlier stages continues to increase, women's expectations of their outcomes following breast reconstruction have grown. The skills and techniques of the cosmetic surgeon are particularly well suited for this group of patients, and there is a prominent role for well trained cosmetic surgeons in the treatment of breast cancer. Aesthetic oncology of the breast seeks to apply the techniques of cosmetic breast surgery to the needs of the breast cancer patient. We will look at techniques and aesthetic outcomes in women undergoing partial mastectomy (lumpectomy) and mastectomy reconstruction with implants and acellular dermal matrix. In addition, treatment of the opposite breast for symmetry, whether by augmentation, mastopexy, or reduction, will be discussed.

10:05 am **Radiofrequency Assisted Liposuction (RFAL): A New Era in Body Contouring**
R. STEPHEN MULHOLLAND, MD

OBJECTIVES: RFAL™, or Radiofrequency Assisted Liposuction, is a new one stage thermal liposuction system that deploys a bipolar radiofrequency body contouring hand piece (Bodytite, Invasix Ltd Israel) to deliver simultaneous coagulation and aspiration of adipose, fibrous and vascular tissue. RF current flows from the internal electrode-cannula to the external epidermal electrode while the physician is performing rapid, controlled lipo aspiration and coagulation through the hallow suction-coagulation cannula-electrode. The continuous monitoring of epidermal temperature and internal adipose impedance, with adjustable and automated RF power cut-off capability, affords the physician an unparalleled ability to deliver heat, control the risks of excessive internal and sub-dermal thermal excess and provide rapid simultaneous aspiration and volumetric tissue heating. Early impressive area contraction of the RFAL treated zones ranges from 25-70%.

METHODS: 35 patients with focal lipodystrophies were treated using a new body contouring technology, Radiofrequency Assisted Liposuction. 29 patients were female and 6 were male and average age was 47.8 years old. Average pure fat aspiration volume was 1.8 liters and the combined aspirates contained a low hematocrit and high lipocrit. Treated areas included the abdomen, hips, thighs, arms and male love handles and breasts. RFAL treatment times were comparable, if not faster that traditional SAL. After tumescent infiltration, the Bodytite RFAL device was used to heat and coagulate the subcutaneous tissue at 2-3 tissue levels and then to elevate the epidermal skin temperature to 42 degrees Celsius, while performing synchronous aspiration of the coagulated soft tissue. Through the continuous measurement and feedback, RF energy cutoff occurred at preset epidermal temperatures and internal impedances

and we were able to maintain the target temperature for a prolonged period of time facilitating both vascular and adipose tissue contraction and coagulation, as well as dermal and soft tissue contraction and shrinkage.

RESULTS: All RFAL lipoplasty procedures were performed without thermal complication and the body contouring recovery process was marked by minimal bruising, swelling and pain. The use of thermal camera technology revealed that the BodyTite provided extremely uniform deep and superficial tissue heating profiles that allowed the uniform subcutaneous tissue contraction and sub-dermal tightening. Average area soft tissue contraction measurements with fixed anatomical points averaged an impressive 35.4%. There was a 2.9% incidence of seroma formation, treated by serial percutaneous drainage and a 17.1% of small, palable, non-visible, subcutaneous fibrous nodules that resolved spontaneously or with lose dose triamcinalone injections be 6 months. There was a 75% incidence of non-symptomatic hypoaesthesia during the first 3 months and a 95% percent return to full sensory return by months. At 6 months 100% were happy with their contour improvements and all patients reported a significant improvement in skin tightening and elasticity.

CONCLUSIONS: RFAL offers body contouring physician unmatched control over adipocyte, vascular and skin coagulation, for less traumatic aspiration and less symptomatic patient recovery. RFAL opens the way to treating patient with compromised skin elasticity and larger volume patients with impressive soft tissue contraction, perhaps obviating the need or the extent of excision procedures in selected patients.

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10:15 am **Statistically Significant Study of Radio-Frequency Assisted Liposuction (RFAL)**
GUILLERMO BLUGERMAN, MD

OBJECTIVES: The current study summarizes statistics of more than 300 patients, with follow-up observations of up to 6 months, after using RFAL technology on various body areas during the past year.

METHODS: The BodyTite device of Invasix Ltd. was used for simultaneous heating of subcutaneous tissue and aspiration of coagulated fat. Aspirated volume varied from patient to patient, ranging from 1L to 5L with deposited RF energy in the range of 40kJ to 300kJ with average energy use of 70kJ per 1L of aspirated volume. Treated areas included inner and outer thighs, abdominal, hips, breasts, and arms. Patients with loose skin and large volumes of adipose tissue were prime candidates for RFAL treatment to benefit from the procedure's tightening effect. Circumference reductions and weight were measured for each treated area and high-resolution photographs were taken for each patient.

RESULTS: Post-treatment analysis demonstrates a stronger tightening effect after RFAL than any other treatment, including laser-assisted liposuction.

CONCLUSIONS: We believe the tightening effect has a thermal nature and requires deposition of high energy into the fat volume. Ex-vivo experiments on adipose tissue show the contraction of connective tissue in the sub-dermal matrix starts at 60-65 degrees centigrade. MRI observations demonstrate thickness reduction of adipose tissue and significant increase of fibrotic tissue over the treated volume. Immediate linear contraction of skin after treatment was approximately 12-15% for the majority of patients and at 3 months follow-up, measurements reached 40% for patients with large volume adipose tissue and loose skin, while for smaller volume patients, contraction was in the range of 15-20%.

10:25 am **Treatment Strategy for Laser-Assisted Lipolysis Based Upon Laser Channel Formation**
MICHAEL J. WILL, MD, DDS

OBJECTIVES: Laser channels generated during laser-assisted lipolysis (LAL) consist of zones of thermal injury surrounding a vacated central hole. LAL devices rely on photothermolysis as the primary mechanism for heating and on the view that thermally induced fat liberation and regenerative healing will enhance retraction and tightening with fibrotic replacement of fat cells. Achieving optimal clinical efficacy, therefore, will depend upon injury profile and distribution of laser channels. The dimensions and characteristics of the laser channel depend upon wavelength, power, device design and treatment technique. To achieve thorough, effective and uniform thermal treatment of adipose tissue, laser channel

formation was first characterized using in vivo histology as a function of power, stroke speed and number of strokes per channel. Channel size was then used to establish treatment protocols evaluated for clinical efficacy.

METHODS: Laser channel formation was characterized as a function of wavelength, power, stroke speed and number of strokes per channel using tissue obtained from abdominoplasty procedures. The channels were characterized with Nitro blue tetrazolium chloride (NBTC) stain to detect loss of cell viability. Treatment protocols, based upon channel size and device settings, were developed to achieve uniform thorough thermal treatment of targeted adipose tissue. Clinical grading and photography were used to evaluate healing and efficacy.

RESULTS: Lower peak temperatures and more uniform volume heating from photothermolytic (radiative) heating requires lipid- or water-selective laser wavelengths with relative low absorption, but lipid-selective wavelengths offer greater efficacy and safety specially near the dermis. Laser channel diameter is shown to depend on laser power, speed of stroking and number of strokes per channel. Larger channels permitted more thorough and uniform treatment of adipose tissue and better fat liberation for easy liposuction. Overall enhancement of skin retraction and tissue tightening was found to be related to laser treatment as well as post-treatment suctioning procedures.

CONCLUSIONS: The laser channel generated during LAL procedures were characterized based upon in vivo histology. The zones of thermal injury surrounding the vacated hole of the channel span dimensions that depend both on device parameters and treatment technique. With optimally designed devices, these channels are reasonably large enabling thorough and uniform treatment of adipose tissue. The role of laser channels as well as post-treatment considerations are discussed and related to achieving optimal thermal benefits.

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10:35 am **Thermal Analysis of Two Lipolysis Energy Sources**
MARK E. SCHAFER, PHD

OBJECTIVES: Ultrasound and laser energy are two of the most common energy sources used for lipolysis. The purpose of this study was to conduct quantitative measurements of the temperature rise caused by two different lipolysis energy sources, using a high resolution thermal camera video system.

METHODS: The primary measurement instrument was an Infrared Camera (FLIR ThermaVision A40 M-FireWire Zoom DE, FLIR Systems GmbH, Berner Str. 81, 60437 Frankfurt, Germany). This camera had a 24° x 17° field of vision, using 320 x 240 bolometric pixels, with a resolution of 80 mK. The absolute measurement accuracy was ±1.0 K, the absolute reproducibility was ±0.5 K, and the relative measurement accuracy was ±0.2 K. A close-up lens (34/80 for 24° objective) was used to provide a spatial resolution of 250 microns. The camera was interfaced to a computer and ThermaCAM Researcher 2.8 Professional software was used to capture the data into an MS Excel file. For this study, bovine fat infused with saline was exposed to laser energy (25W, 980nm, 1-second duration) and to VASER ultrasound energy (100% setting, 3.7 mm, 2-ring probe, 1-second duration). Video recordings were made over a 10-second timeframe (before, during and after activating the energy source); the video sampling rate was 60 frames per second. In addition, an analysis region which included the active region of each energy source was established, in order to provide a time history of the maximum tissue temperature.

RESULTS: Tissue exposed to the laser reached 50°C (ability to denature proteins) in less than 50 milliseconds and 100°C (boiling point) in 100 milliseconds. Data extrapolation estimated the highest temperature to reach 484°C (this temperature exceeded the maximum value of the measurement instrumentation, which was limited to 265°C). In comparison, at 1 second of use, the tissue exposed to the VASER probe increased only 9°C. Graphical data indicated that the temperature rise for the laser was essentially immediate, while the VASER produced a slower thermal curve. Further, the video indicated that the VASER produced a swirling of fluid around the probe, which served to disperse any temperature concentrations. The laser showed no similar dissipative fluid motion, although there was some motion caused by the boiling of the infusion fluid.

CONCLUSIONS: The laser system was found to produce extremely high, uncontrolled temperatures that were sufficient to vaporize tissue and potentially damage structures within the body. The laser system created these excessive temperatures within one tenth of a second after activation. Conversely, the VASER probe did not produce damaging temperatures at typical use conditions.

While laser lipolysis has become well known for limiting blood loss and improving recovery time, it is limited to small procedures and does not allow for harvesting of viable fat cells for additional procedures. As more powerful lasers have come onto the market, issues of patient safety and the possibility of severe burns have become more critical.

VASER Lipo utilizes acoustic forces to safely dislodge adipocytes while protecting surrounding tissues, which is critical for concurrent treatments such as AFT.

10:45 am **Histological Comparison of SmartLipo and CoolLipo Laser Lipolysis**
NEIL S. SADICK, MD

OBJECTIVES: The aim of this study was to evaluate the safety and efficacy of the smart lipoplasty (SmartLipo™, 1064 nm) and cool lipoplasty (CoolLipo™, 1320 nm) in abdominoplasty specimens.

METHODS: Lipoplasty using the SmartLipo™ technique was performed using energy levels of 150J, 350J and 500J at 6W. Lipoplasty using the CoolLipo™ technique was performed using energy levels of 150J, 350J and 500J at either 8W or 12W.

RESULTS: For SmartLipo™ no effects were visible at 150mJ 6W. At 350mJ 6W the coagulative thermal effects were seen in mid and deeper reticular dermis and subcutis in 1 of 5 specimens. In the remaining 4 samples there were no discernible morphologic alterations.

For CoolLipo™ at 150J 8W fat coagulation was noted in 5 out of 6 specimens. In 3 of these 5 specimens, mid and deep dermal coagulation was present. At 350J 8W fat coagulation was present in samples from all 6 patients. In 4 out of 6 specimens very focal epidermal necrosis and mid and deep dermal coagulation were seen.

CONCLUSIONS: In order to achieve significant fat coagulative effects and obtain deeper dermal remodeling without superficial dermal coagulation, the CoolLipo™ technique at 350J and 8W or 12W appears to be optimal. Extensive coagulative changes were not seen in any of these cases.

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10:55 am **Device Design for Optimum Laser Channel Formation in Laser-Assisted Lipolysis**
JAMES J. CHILDS, PHD

OBJECTIVES: Laser-assisted lipolysis (LAL) devices are currently used as adjuncts to liposuction with the primary objective to heat the adipose and connective tissue in a controlled manner. Available LAL systems' design parameters vary significantly across choice of wavelengths, power delivery and tip design. This work describes rationale for an optimum laser channel and evaluates with physical principles the selection of device parameters with regard to its formation. The principles are illustrated in experiments and controlled ex vivo tests that include comparison of two LAL devices with distinctly different wavelengths, power delivery and tip designs.

METHODS: A computer model for thermal conduction, radiation propagation in adipose tissue and coagulation was developed to study the relationships between laser parameters and laser channels in human adipose tissue. An ex vivo study with Yucatan Black porcine tissue compared laser channels created by two distinctly different LAL devices, one that operates in short-pulse mode with a 0.6mm diameter fiber emitting lipid non-selective laser wavelengths, and another that operates in CW mode with a 1.5mm diameter fiber emitting lipid-selective and water-selective wavelength lasers. The channels were characterized with Nitro blue tetrazolium chloride (NBTC) stain to detect loss of cell viability.

RESULTS: Photothermolytic (radiative) heating is the optimum mechanism to control delivery of heat to the tissue. Fiber tip surface power density can be optimized for ease of penetration and good volumetric heating while avoiding extremely high peak temperatures. Continuous wave, rather than pulsed laser emission also minimizes peak temperature rise at the tip that can interfere with laser channel formation. Lower peak temperatures and more uniform volume heating also require lipid- or water-selective laser wavelengths with low absorption but lipid-selective wavelengths offer greater safety near the dermis. Histology of porcine samples characterizes the laser channels formed by the two devices. At similar power settings there is greater volumetric heating by the CW, lipid-selective device. Laser channel diameter is shown to depend on laser power, speed of stroking and number of strokes per channel.

CONCLUSIONS: A laser channel produced during LAL procedures has been described and characterized on physical grounds as well as with histology from ex vivo treated tissue. The zones of thermal injury surrounding the vacated hole of the channel span dimensions that depend both on device parameters and treatment technique.

11:05 am "The Stork Lift":
A Circum-Occipital Extended Neck Lift
HARRY MARSHAK, MD

OBJECTIVES: The goal of the lower face and neck lift is the restoration of a sharp cervicomental angle. However, standard cervical rhytidectomy on the patient with extensive excess skin of the neck will often leave the patient with objectionable vertical and/or diagonal skin folds of the lateral neck and/or a large hair-step deformity. In order to remove extensive excess skin of the neck and avoid vertical/diagonal folds and a stepped hairline, the authors "walk" the excess skin posteriorly along the hairline, often from ear to ear along the inferior posterior hairline.

METHODS: Patients with extensive excess skin of the neck underwent neck lift procedures using the circumocciput incision technique during a period of 1 year. With the patient in a sitting position, the post-auricular facelift incision is extended along the inferior hairline from ear to ear. The flap is "walked" posteriorly to and along the occiput on either side of the midline. It is closed in a divide and close technique. Flaps are created and the wound is closed in a multi-layered fashion with a posterior midline A-to-T flap.

RESULTS: 25 patients (22 females, 3 males) underwent cheek/neck lift and 2 patients (one male, one female) underwent isolated neck lift procedures using the circumocciput incision technique during a period of 1 year. Average age was 64.8 years (range 49-79). There were no instances of obvious lateral neck folds. Complications included one patient with hematoma, one patient with candida wound infection and one patient with a widened scar that was revised secondarily. All patients were satisfied with their cosmetic result at 6 months post-op. None of the patients stated that their final scar was noticeable and/or objectionable.

CONCLUSIONS: Patients in this study who presented with excessive excess skin of the neck were treated with the "Stork lift" which provided excellent lifting of the anterior, lateral and posterior neck as well as excellent cervicomental angles without the post-operative sequelae of lateral neck folds or stepped hairlines.

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11:15 am **Liposonix – Effective Nonsurgical Body Sculpting with HIFU**
AFSCHIN FATEMI, MD

OBJECTIVES: Liposonix is thought to be a nonsurgical treatment for body contouring using HIFU, a high intensity focused ultrasound, to disrupt adipocytes percutaneously. We want to find out about efficacy, effectiveness and so forth.

METHODS: The technique delivers energy across the skin surface at a relatively low intensity, but brings this energy to a sharp focus in the subcutaneous fat. At the skin surface, the intensity of the ultrasound energy is low enough so that no damage occurs. The focusing of the ultrasound beam at specific depths beneath the epidermis, combined with proprietary application techniques, results in adipose tissue disruption.

Once adipocytes have been disrupted, chemotactic signals activate the body's inflammatory response mechanisms. Macrophage cells are attracted to the area to engulf and transport the lipids and cell debris. This results in an overall reduction in local adipose tissue volume. Our clinical and histological studies will show exactly what happens under the skin. We did a series of studies on gross pathology and histology, and tried to correlate these to the clinical results.

RESULTS: The studies show clearly that adipocytes are disrupted by HIFU. The correlation between focal depth, energy levels and clinical results is evident. The average circumference reduction after treatment of abdomen and waist is 4-5cm. The presentation will also discuss the reasons for the so far seen skin tightening and possible complications due to the treatment.

CONCLUSIONS: Liposonix turns out to be a safe and effective technique for nonsurgical body sculpting by reduction of fat deposits.

11:25 am **Laserlipolysis or Laserfibrolysis**
GERHARD SATTLER, MD

Information not available at press time.

11:35 am **Panel Discussion – Managing Difficult Problems in Cosmetic Body Surgery**

Moderator: E. ANTONIO MANGUBAT, MD

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

1:30 – 3:30 pm **General Session 203: Cosmetic Body Surgery**

Moderators: GERHARD SATTLER, MD AND QUITA LOPEZ, MD

1:30 pm **Post-Bariatric Plastic Surgery**

SIAMAK AGHA-MOHAMMADI, MD, PHD
FEATURED SPEAKER

OBJECTIVES: Gastric bypass surgery (bariatric surgery) or massive weight loss leaves a spectrum of changes that most patients find unpleasing. For some, a near normal appearance may be the result; but more often, excess soft tissue and skin persist throughout the face and body. After the weight loss, many patients experience significant changes in the form, shape, and contour of their arms, upper chest, breasts, back, buttocks, abdomen, thighs, and calves.

METHODS: The female physique embodies the true sense of a three-dimensional shape in space. It not only represents curves in a two-dimensional hourglass form, but also curves that are appreciated as the bust in the front and the buttock in the back. Unfortunately, the body lift procedure is a purely one-dimensional correction of the vertical tissue laxity. It does not correct for the circumferential laxity nor for the lack of contours and projections. Dr. Agha performs his signature High-Definition Body Lift™ that aims to return a three-dimensional correction to the tissue laxity. This involves correction of both vertical and circumferential laxity, as well as the third dimension of projection and contour. The latter is most applicable to the breasts, the lower back, the buttocks and the abdomen.

RESULTS: Typically, Dr. Agha performs a Total Body Lift in 2 stages: one stage will address the lower body and another stage the upper half. The lower body contouring involves a lower body lift with circumferential abdominoplasty and buttock lift, buttock augmentation with autologous tissue and a thigh lift.

CONCLUSIONS: The upper body contouring typically involves an extended brachioplasty, an upper body lift, and breast reshaping. For those with existing large breasts and sagging, Dr. Agha commonly performs a breast reduction with internal breast lift by employing the dermal bra suspension technique. For others who require breast volume, Dr. Agha offers either the use of breast implants or your own excess upper body tissue as flaps for breast augmentation. Both breast reshaping and upper body lift are thus performed simultaneously.

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2:00 pm **Liposuction Associated with Abdominoplasty**
VIMAL MALIK, MD

OBJECTIVES: Achieving youthful abdominal contour by Abdominoplasty is a common desire of many cosmetic surgery patients. This group contains people who either had sufficient degree of weight loss or lost the normal abdominal contour post natal. In the last three years author performed 65 abdominoplasties with good results.

METHODS: Patients selected for this study were divided into two groups. First group contained patients who were subjected to abdominal fascia tightening along with abdominoplasty while second group was subjected to liposuction removing 1.5 to 2.5 liters of fat from front and sides of abdomen prior to abdominoplasty. No drain was put in either of the two groups. If serous collection was found after one week of surgery it was aspirated by a 20 cc syringe and pressure garment was given.

RESULTS: Group one where only fascia tightening with abdominoplasty was done had generally a lower level of satisfaction and still longed for a leaner figure. Group two where liposuction was performed along with fascia tightening and abdominoplasty were completely satisfied with the outcome.

CONCLUSIONS: Liposuction with abdominoplasty has better results the abdominoplasty alone.

2:10 pm **Treatment of Skin Necrosis following a Modified Avelar Abdominoplasty with the 635nm Low Level Laser and Platelet-Rich Plasma**
QUITA LOPEZ, MD

OBJECTIVES: Skin necrosis and delayed wound healing are complications of abdominoplasty surgery. A case report is presented where a 62 y/o female patient was treated with the 635 LLLT and PRP. Both modalities work in synergy to accelerate wound healing and improve the final appearance of the scar.

METHODS: A case report. Background on the Avelar abdominoplasty technique will be discussed. Advantages of saving the neurovascular bundle addressed. Modified Avelar technique used described.

RESULTS: A 62 y/o female developed a large skin necrosis following a modified Avelar abdominoplasty. The patient was treated with daily 635 LLLT treatments to reverse some early signs of skin necrosis. PRP was placed in the open wounds to accelerate the granulation phase of wound healing. Background on both treatment modalities will be presented as well as other conventional treatments for flap necrosis. Complication rates reported in literature for skin necrosis mentioned. Both treatment modalities shortened the healing phase and resulted in an acceptable final scar that did not need revision.

CONCLUSIONS: Ischemic flaps can be treated with the LLLT and PRP. Both modalities work in synergy to accelerate wound healing and improve the final aesthetic appearance of the scar so future corrective surgery is avoided. Morbidity is also decreased by avoiding potential complications with open wounds.

2:20 pm **Retrospective Data Analysis Comparing Laser Assisted Liposuction versus Power Assisted Liposuction and Stem Cell Breast Augmentation**
JEFFRY B. SCHAFER, MD

BACKGROUND & OBJECTIVES: Retrospectively analyzed outcomes in patients receiving laser assisted liposuction (LAL) versus suction assisted liposuction (SAL) or power assisted (PAL).

STUDY DESIGN/MATERIALS & METHODS: Medical records of 234 subjects were analyzed: 107 patients with SAL between 2008 and 2009 compared to 127 subjects treated with PAL or SAL in 2007. Demographics, methods of tumescence and suctioning were similar. The demographics were very similar, BMI and average weight for both groups. Complications were defined as anticipated reactions that may not resolve without medical intervention and side effects as those that eventually resolved.

RESULTS: Complications in 1 and 3 month follow-up were 69% and 88% reduced. Side effects were 74% and 79% reduced for the LAL treated subjects.

CONCLUSION: LAL appears to have a safer outcome and reduced side effects and revisions.

Stem Cell Facelift and Breast Augmentation: Using new technology of the lipo kit and max stem coined the Rejuva Lift™ it is possible to increase cup sizes one or two cups and improve facial appearance.

- The method is with lipocondensation of young fat cells combined with additional stem cells and regenerative cells through incubation process and reinjecting them into the face or breast areas.
- The addition of stem cells and regenerative cells greatly enhances the survivablity of the fat grafts to the face and breast.

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2:30 pm **New Clinical Outcomes Utilizing a 1064nm Nd:YAG Laser for Lipolysis of the Torso Oblique Region**

NEIL S. SADICK, MD

OBJECTIVES: The safety and efficacy of a 1064-nm Nd:YAG laser (Cynosure, Westford, USA) utilizing a 300-µm optical fiber and a 1-mm diameter micro-cannula were evaluated as a treatment for reduction in the appearance or elimination of unwanted fat in the lower back/flanks ("love handles"), In addition, the use of the laser for tightening the skin and collagen regeneration in the area of lipolysis was assessed through biopsies.

METHODS: Ten subjects with unwanted flaccidity and fat deposits in the oblique region of the torso were enrolled in the study. Subjects underwent a single laser lipolysis treatment followed by aspiration of the treatment area. The total tumescence used, laser energy delivered, and tissue removed was recorded for each subject. All subjects had baseline photographs and their weight taken prior to treatment. Pregnancy tests (if applicable) were performed prior to treatment as well. Three subjects had 4-mm biopsies taken at baseline and 6 months to evaluate collagen regeneration. Collagen and elastic tissue fibers were evaluated using special routine stains and histochemical stains designed to highlight these dermal components. Follow-up visits were conducted at one (1) week, one (1) month, three (3) months and six (6) months following treatment to evaluate side effects, weight loss and laxity. Additionally, patients kept an evaluation log for each of the first seven days following treatment. At the 6-month conclusion, patient satisfaction was recorded.

RESULTS: Laser lipolysis procedures with subsequent aspiration were performed bilaterally on the flanks of ten (10) subjects. At one week post treatment, 80% of the subjects demonstrated reduction in laxity. Similarly, 100% of patients showed visible skin improvement at one month, with 70% recording a score of 2 (good improvement). Three month evaluations yielded one patient (10%) with a score of 3 (excellent improvement) and seven patients (70%) with a score of 2. Histology reports confirmed the visual clinical outcomes, describing thicker collagen bundles at 6 months, as well as coagulation of blood vessels and adipocytes. Side effects were mild and transient in nature, and the majority of discomfort, redness, bruising, swelling, and tingling experienced was resolved within one week post-procedure. The treatment was well tolerated and efficacious, with 90% of patients rating their results as good or excellent and 100% of patients reporting that they would recommend the procedure.

CONCLUSIONS: The use of the 1064-nm Nd:YAG laser with a 300-µm fiber demonstrated the ability to treat adipose tissue in the highly vascular flank area with favorable efficacy and safety. Patients exhibited a quick recovery time, excellent tolerance, as well as visually improved skin.

2:40 pm **Brachioplasty: How to Choose the Correct Operation**
CHASBY SACKS, MD

OBJECTIVES: To provide an easy logical method for choosing the correct Brachioplasty procedure.

METHODS: How to examine the patient, what to look for and how to use these findings in choosing the correct procedure will be discussed with easy to understand diagrams of the different pre-operative findings and diagrams of the different operations to use for those conditions.

RESULTS: After understanding this systematic approach correct choice of procedure will be facilitated.

CONCLUSIONS: Many choices are available in Brachioplasty operations. A systematic approach will make the correct choice easier.

2:50 pm **The Art of Back Liposculpture**
JOSE SALAS, MD

ABSTRACT: Abstract mentions guidelines that we have followed for the pasted years in patients that undergo liposuction. We should know and explain to our patient the possible result from this type of procedure. We have to illustrate our patient on the areas that will be operated on, following a process so patient knows where we will start the procedure and finish. We will demonstrate with before and after photographs the aesthetic improvement of these patients. It is very important to examine patient pre-op and trans-op, verifying final results from patient's expectations. All liposuctions are performed with an epidural, modified tumescent solution and atraumatic cannulas (3-6 mm).

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3:00 pm **An Algorithm for Management of Gynecomastia**
MOHAN THOMAS, MD

OBJECTIVES: Treatment options for gynecomastia include open excision, liposuction and various patterns of skin excision. The selection of treatment plan depends on the grade of gynecomastia.

We propose an algorithm in management of gynecomastia taking into account the degree of skin laxity.

METHODS: 100 cases of gynecomastia were treated effectively using a protocol.

Patients without skin laxity were all treated by liposuction alone. Complete glandular excision and fat removal could be achieved with liposuction alone.

Cases with mild skin laxity were treated with a helmet design skin excision described by the author. Peri areolar excision is also a viable alternative federate skin excess correction.

Gynaecomastias with severe skin laxity as in post massive weight loss were treated with a boomerang shaped skin excision as described by Hurwitz.

RESULTS: Complete correction of gynecomastia could be achieved in all cases. A normal chest contour without residual gland tissue or defects could be achieved in all the cases.

The helmet design excision of skin excess in moderate skin excess results in minimal visible scars and adequate correction. The boomerang excision should be reserved for cases with severe skin excess only.

CONCLUSIONS: Gynecomastia of various grades can be corrected effusing an algorithm.

The proposed algorithm makes the selection of treatment option easy and ensures high success rates.

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3:10 pm **Male Breast Surgery**
VIMAL MALIK, MD

OBJECTIVES: Male breast is quite an embarrassment to all suffering patients. They all look for a procedure which is less traumatic and has substantial results.

METHODS: Above 150 males were taken for the study on improvement of gynaecomastia.

(A) 35 patients in which gynaecomastial mass were excised surgically; (B) 50 patients liposuction and surgical excision; (C) the rest were subjected to liposuction only.

(A) In surgical group periareolar incision was given after injecting normal saline with adrenaline all over the breast tissue including the space between breast and pectoral fascia. Fine dissection was carried out and whole breast was removed in one piece with tube drain put into the space and pressure bandage was given.

(B) This group mostly had patients who were in their early 20s with true gynaecomastia. They were operated under general anesthesia or under local anesthesia. Normal saline and with adrenaline was injected into the inframammary space. One small cut was made at the lower periphery of each breast. Standard tumescent fluid was breast incision (less then a centimeter) of the each side on the lower periphery of the breast. Standard liposuction was done on each breast, in certain cases redundant breast tissue was removed with the help of long dissecting scissor and breast issue adherent to pactoral facia was removed. Care had been taken not to injure the pectoralis muscles. Drain was put in some cases where bleeding was expected pressure bandage was given while in other cases no drain was put.

(C) Group had both old and young patients who had gynaecomastia due to obesity. They were subjected to standard liposuction and no drain was put in all cases.

RESULTS: As compared to all the procedures surgical removal had least cosmetic results. As a crater is formed post surgery and the patients also had altered nipple sensation, while in second and third group no such complication was seen and patients were happy with a flatter chest.

CONCLUSIONS: In cases of true gynaecomastia, liposuction along with minor dissection is ideal while in other cases simple liposuction is good enough.

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3:20 pm **Minimal Incision Male Breast Reduction with Laser Assisted Liposculpture**
ROBERT H. BURKE, MD, DDS

OBJECTIVES: Describes a reproducible technique involving minimal incisions, aided by dual wave near infrared laser lipolysis to reliably reduce gynecomastia.

METHODS: A reproducible minimal incision technique for treatment of gynecomastia is outlined. This involves infiltration of the breast region with Klein solution, subsequent dual wave (1064nm and 1320nm) laser lipolysis followed by liposculpture.

RESULTS: Males with minimal to moderate ptosis may be treated with this minimal incision technique. A compression garment is used postoperatively which permits nearly unrestricted activity as early as 2 days postoperatively. Patients may resume weightlifting within 14 days. Recovery has been uneventful.

CONCLUSIONS: A minimal incision technique for male breast reduction is described. This may be applied to minimal and modest ptosis. An additional advantage is rapid postoperative recovery. Patient satisfaction is high. Complications have been minimal and self correcting.

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

4:00 – 5:30 pm **Cosmetic Surgery Essentials: 204**
(Sessions will run concurrently)

BREAKOUT #1

Location: Wekiwa 1&2

Advanced Fat Grafting Techniques: Face and Body

Mark Berman, MD, Suzan Obagi, MD and Ziya Saylan, MD

These 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. They will also 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. Additionally, Dr. Saylan will present information about his recent experiences with stem cells derived from fat.

BREAKOUT #2

Location: Wekiwa 3&4

Cosmetic Surgery Hospital Privileges: Applying for Privileges, Upholding Your Rights, and Responding to Improper Oppositions
Peter A. Gaido, Esq., Gaido & Fintzen

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 developed the comprehensive Privileging Block Informational Packet to arm physicians with information to protect their legal rights and oppose their competitors' improper attempts to preclude them from obtaining cosmetic surgery privileges. Specifically, the Packet is designed to assist physicians facing privileging blocks, and provide vital information to those applying for cosmetic surgery privileges. Peter Gaido, the Academy's General Counsel and co-author of the Packet, will discuss the contents of the Packet and its application to physicians seeking, or being blocked from obtaining, cosmetic surgery privileges.

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BREAKOUT #3

Location: Wekiwa 5

The Art of Rhinoplasty

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

Rhinoplasty, when broken down to its lowest common denominator, simply involves taking apart the different anatomic units, reducing, or augmenting them and then putting them all back together in a cohesive unit that will hopefully heal without undue scarring or fibrosis. The latter are the variables not totally under the control of the surgeon. The boney nasal pyramid is lowered, narrowed with osteotomies or augmented with autologous grafts. The upper cartilaginous framework consisting of the upper lateral cartilages and the septum is similarly lowered, with independent trimming of the dorsal border of the upper laterals to lie above, at or below the septum depending upon the skin thickness, and nasal width. Frequently in revision surgery, autologous cartilage is grafted to correct over resection, or asymmetry of the dorsum. The lower cartilaginous framework consisting of the caudal end of the septum as well as upper lateral cartilages with the lower lateral cartilages present the biggest challenge to the surgeon. This presentation will review some of the basic tenants learned the hard way after 32 years. From treatment of full thickness skin loss in the tip to correcting the crooked nose with illusionary autologous grafts one will hopefully be able to incorporate this information in their practice the easy way, by listening as opposed to the school of experience.

This seminar will explore multiple methods for the management of the cosmetic and functional aspects of rhinoplasty. Emphasis will be on patient selection, treatment options, surgical techniques, and complications. Participants attending the seminar should be able to appreciate the variations in nasal anatomy, have an understanding of various methods for altering nasal aesthetics, understand the techniques for the different approaches and know the possible complications of these procedures.

BREAKOUT #4

Location: Wekiwa 7&8

The Art of Bariatric Cosmetic Surgery and Body Contouring

Michael H. Rosenberg, MD and Siamak Agha-Mohammadi, MD, PhD

Information not available at press time.

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BREAKOUT #5:
COSMETIC BREAST SURGERY

Location: General Session – Gatlin C Ballroom

Moderators: ROBERT A. SHUMWAY, MD AND
ROBERT H. BURKE, MD, DDS

4:00 pm **A Comparative Analysis of Factors Associated with Outcomes in 401 Women Undergoing Cosmetic Breast Augmentation Procedures over Four Decades**
KATHRYN SPANKNEBEL, MD

OBJECTIVES: The true natural history and complication rates of cosmetic breast augmentation (CBA) procedures are not well defined. This study was conducted to determine factors associated with patient outcomes, reoperative events, implant longevity, and patient satisfaction over time.

METHODS: A consecutive, retrospective review of patients undergoing initial CBA (Group A) or CBA and related secondary intervention(s) (Group B) at a single center over a 5-year period by specialists in a group practice was performed. Descriptive statistics were used to characterize patient demographics, operative detail, implant longevity, and complications requiring revision surgery over time. A comparative analysis was performed using multivariate regression analyses to determine patient-, procedure-, and implant-related factors associated with outcomes, $p \leq 0.05$ defined significance.

RESULTS: 401 women underwent either an initial CBA (Group A; n=253) or CBA and related secondary intervention(s) (Group B; n=148) at a median follow-up of 56 months (92% patients with available data).

Overall, morbidity rates were significantly lower in Group A vs. B patients (0.2 vs.1.50, $p<0.001$). Implant longevity was significantly associated with the requirement for secondary procedures (30.6 vs. 59.5 months, Group A vs. B, $p<0.001$). The two most common implant-related factors associated with reoperation included capsular contracture (5% vs. 26%) and implant rupture (5% vs. 22%), $p<0.001$. Scar deformity (17.5% vs. 11.5%), rippling (17.5% vs. 9.5%), pain (25% vs. 11%) and changes in nipple sensation (10% vs. 8%) were more commonly reported in Group B patients, however less commonly led to secondary interventions ($p \leq 0.05$). Technical issues surrounding implant size (5% vs. 11%) and infection/extrusion complications (2% vs. 7%) were significantly associated with reoperation in Group A vs. B patients ($p<0.02$), while implant position (7.5% vs. 10%), symmetry (5% vs. 9%), and ptosis (5% vs. 9%) problems were not (p=NS).

It follows that the majority of corrective procedures used in Group B patients involved the removal and replacement of implants (n=83,56%), capsule-related procedures (n=49,33%), mastopexy (n=27,18%), and scar revision

(n=13,9%). Interestingly, Group B patients (18/47, 38%) were also more likely to undergo concomitant breast procedures at the time of initial implant compared to Group A patients (35/151, 23%) which underscores the operative complexity of this patient group, in general (p=0.02).

Patient-directed revision procedures were significantly related to those with a psychiatric history (8% vs. 16%, p=0.01), reported alcohol use (11% vs. 17%), and those with a history of prior cosmetic surgery (procedure rate/patient 0.7 vs. 1.8, p=0.02), Group A vs. B patients, respectively. Smoking history, body mass index, median age at augmentation, and single status were not significantly different between patient groups.

CONCLUSIONS: These data from a diverse group of referred patients treated in a multi-specialty practice demonstrate several factors likely related to poorer outcomes and secondary operative interventions in the cosmetically augmented patient. Efforts to reduce capsular contracture and implant failure are needed since these factors significantly impact reoperative rates over time. Likewise, physicians selecting candidates for augmentation mammaplasty should take steps to screen for those with significant psychiatric history, alcohol use, or prior cosmetic procedures since these patients may require more careful management of expectations.

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4:10 pm **Fat Transfer Breast Augmentation (FTBA) and Breast Reconstructive Techniques Utilizing Water Assisted Liposuction (WAL) and Adipose Derived Adult Stem and Regenerative Cells (ADASRC's)**
TODD K. MALAN, MD

OBJECTIVES: Autologous fat transfer for breast augmentation and reconstruction has remained a highly debated and controversial procedure following the introduction of these techniques in the U.S. in the late 1980's. Concerns regarding poor graft, survival, calcifications, liponecrotic cysts, and obscuring mammography had relegated this procedure to little more than a historical footnote. Recent advances in fat harvesting and transfer techniques, digital mammography, and the use of adipose derived adult stem and regenerative cells (ADASRC's) necessitate a re-examination of this longstanding bias against fat transfer breast augmentation (FTBA).

Saline or silicone implants are considered the standard for cosmetic breast augmentation and reconstruction. Complication rates for these procedures are general accepted to be as high as 25% with a re-operation rate of 100% at 10 years. Additionally, implants can obscure 15-50% of normal breast tissue on screening mammography making early detection or follow-up of cancer more difficult. Early FTBA technique studies demonstrated a graft survival rate of between 35-50%. Calcification rates with concern for potential obscuring of mammography were noted in 2-40%. Attempts to enhance fat graft survival have focused on the development of low-pressure atraumatic closed system harvesting techniques. Recent studies have also recognized the importance of ADASRC's in fat graft survival, repair and regeneration of damaged tissue, as well as a source for multipotent stem and mesenchymal stromal cells.

METHODS: 20 patients underwent WAL assisted fat harvesting for the purpose of FTBA. Harvested fat was processed and graft specimen enriched with ADASRC's utilizing the Stem Source™ device by Cytori Inc. (San Diego, CA) Patients received pre- and postoperative volumetric and breast imaging analysis utilizing MRI and US. Patient also completed patient satisfaction scores.

RESULTS: Fat survival range 65-95%. Avg 87%, Calcification Avg 13%, Liponecrotic Cysts 8%.

CONCLUSIONS: FTBA is a safe and effective option for breast augmentation and reconstruction. Our experience in performing FTBA utilizing the Body-Jet™ (Eclipse Medical, Dallas, TX) WAL device for fat harvesting and the Stem Source™ device by Cytori Inc. (San Diego, CA) to process WAL harvested fat for the purpose of obtaining graft specimen enhanced with ADASRC's demonstrated favorable results as compared to historical methods for FTBA.

4:20 pm **Three-dimensional Photo Simulation as a Predictor of Augmentation Mammaplasty Outcomes**
BRETT S. KOTLUS, MD

OBJECTIVES: Breast enhancement surgery requires preoperative planning in regard to implant size and shape. Factors to consider include pre-existing anatomy, surgeon judgment, and patient expectations. Three-dimensional imaging systems can simulate possible surgical outcomes while permitting modification of computerized implant variables. Ultimately, the aim of computer simulation is to aid in communication between surgeons and patients in visual terms.

METHODS: 25 consecutive patients with no greater than grade I nipple ptosis were photographed with a three-dimensional photo system (VECTRA, Canfield Imaging Systems, Fairfield, NJ) prior to augmentation mammaplasty. Implant shape and size were selected at the time of computer surgical simulation (Breast Sculptor software, Canfield Imaging Systems, Fairfield, NJ). Postoperative photographs were compared to simulation images by 2 independent evaluators with a 0 – 4 rating system for degree of similarity in size and shape separately.

RESULTS: A high degree of similarity in both shape and size were observed in patients without glandular ptosis. Patients with glandular ptosis were highly similar in size but not in shape. The ability of the implant to disguise glandular ptosis was underestimated by the three-dimensional simulation. All patients were satisfied with surgical results and were pleased with the availability of the preoperative simulation images.

CONCLUSIONS: Three-dimensional breast surgery simulation systems are useful tools in appropriately selected patients. Patient expectations and desires can be identified and discussed with the assistance of real-time images. The currently available software will benefit from future tools that allow for mastopexy simulation and more realistic morphing capabilities in patients with glandular ptosis.

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4:30 pm **Vertical Mastopexy With Breast Augmentation Using Cohesive Gel Implants**
ROBERT H. BURKE, MD, DDS

OBJECTIVES: Describe the Michigan Center for Cosmetic Surgery experience with the combination of breast augmentation and vertical mastopexy using silicone cohesive gel implants.

METHODS: Case review including chart review and examination of patients treated at MCCS for the combination of ptosis and hypomastia. All patients participated in preoperative implant size selection. A vertical mastopexy, individualized for the patient was combined with subpectoral insertion of cohesive gel implants. Incisions usually were periareolar although occasionally an inframammary incision was used where there was a previous scar or the implant was much larger than the NAC.

RESULTS: There was a high degree of satisfaction with the results of the procedure. The universal comment was that the breasts felt like natural tissue. There were no hematomas or loss of implants. Two superficial infections occurred along the mastopexy incisions. One was positive for E.coli, the other positive for pseudomonas. Each responded to oral antibiotics and localized wound care.

CONCLUSIONS: The combination of vertical mastopexy with insertion of cohesive gel silicone breast implants addresses both hypomastia and ptosis. Combining the procedures has the advantage of avoiding a second surgery.

4:40 pm **Augmentation Mastopexy for Moderately to Severely Ptotic Breasts: Previsualizing Breast Shape and Symmetry With an Innovative and Versatile Stapling Technique**
TED EISENBERG, DO

OBJECTIVES: Augmentation mastopexy is one of the more challenging surgeries. This article presents a new technique in which tailor tacking with skin staples provides maximum tightening of the redundant breast tissue and allows me to pre-visualize breast shape and symmetry – before the scalpel is raised for a one-stage skin resection. I believe this is a more precise approach than the standard technique of drawing a pattern, resecting skin and then tailor tacking the tissues together.

METHODS: A total of 41 patients with moderate to severe ptosis and hypotrophy were reviewed for this article. They all had bilateral submuscular saline breast augmentation with bilateral mastopexy with this stapling technique. Surgeries were performed over a

five-year period. The technique is described in detail. Pre- and post-operative photographs are provided.

RESULTS: Patients reported great satisfaction with their results. Only 6 had small areas that healed by secondary intention and only 1 patient had a mildly hypertrophic scar. Subjectively, this technique allowed me to achieve consistent, reproducible symmetry with single en bloc tissue resection and with less anxiety and guesswork.

CONCLUSIONS: This augmentation/mastopexy technique produces predictable and reproducible results regardless of the implant size or the amount of skin that needs to be resected. With the adage of measure twice, cut once, it's very comforting to be able to preview the surgery results before having to cut skin.

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4:50 pm **No Vertical Line Mastopexy with Breast Hang**
OMAR RASHAD, MD

OBJECTIVES: Although there is an abundance of data in the literature regarding the breast reduction and augmentation, nearly all of the literature concerning mastopexy describes inverted T techniques and its complications. There are few studies regarding periarolier with no vertical line mastopexy.

METHODS: A retrospective review was performed on a series of 50 consecutive patients who underwent a mastopexy procedure. Operations were performed by me in an outpatient surgery center over a 3-year period (2004-2007), with an average follow-up of 18 months. Patients were identified as being either primary (no previous breast surgery) or secondary (history of at least one previous breast surgery). The mastopexy design was no vertical line, periareolar and inframammary and breast hang performed by two deep stitches to pectoralis major muscle using proline 0, and trends were examined. Complication and revision rates were observed, and their rates were calculated.

RESULTS: All women underwent bilateral mastopexy for a total of 100 breasts. There were 39 primary and 11 secondary patients. Mastopexy incision designs were as described before. There were no major complications. The most common complications were poor scarring (12%) and seroma formation (3%). The revision rate was 12% of revisions were for poor scarring. Some of these were performed with the patients under local anesthesia or at the time of a subsequent unrelated surgery.

CONCLUSIONS: Our series of 50 consecutive patients, with no major complications and a revision rate of 12% over an average of 18 months, indicates that mastopexy may be considered a safe and effective procedure.

5:00 pm **Minimal Invasive Breast Reduction and Mastopexy**
GUILLERMO BLUGERMAN, MD

OBJECTIVES: We are looking for the way to avoid skin scars in the patient that would like to reduce his breast volume or elevate the ptotic tissues.

METHODS: We are combining different methods and equipment in order to promote the skin contraction, glandular and fat reduction and ligaments tightening We will show our experience after the use of fractional CO2 resurfacing (Pixel CO2), RFAL (Radiofrequency Assisted Liposuction) with Body Tite, and skin subcition in combination with threads placements in specific vectors in order to promote the adherence of tissues in antigravitational position promoting a breast lift effect.

RESULTS: The results after the application of this techniques are age dependant. Skin quality is a very important factor at the moment of results evaluation. Patient satisfaction rate was high.

CONCLUSIONS: The authors present his preliminary results obtained on breast reduction and mastopexy by use of novel RALS (Body Tite by Invasix) in the mammary tissues in combination with other internal and external maneuvers.

5:10 pm **Fillet Technique in Inferior Pedicle Breast Reduction to Achieve Better Results**
MOHAN THOMAS, MD

OBJECTIVES: The wise pattern inferior pedicle breast reduction is probably the best technique in massive reductions. The technique relies on lateral and medial resections to achieve the parenchymal and skin excess reduction. Aggressive resection of lateral and medial flaps puts a lot of tension of the closure and can lead to suture line dehiscence.

To achieve increased overall reduction, the superior flap also needs to be reduced in bulk. A safe and predictable method is described to achieve debulking of the superior flap in wise pattern reductions.

METHODS: In 50 consecutive cases of breast reductions using the inferior pedicle wise pattern reduction, the superior flap was debulked by a fillet technique. The deeper layer of fat in this flap was removed as a large fillet by dissection under vision using an electro cautery or harmonic scalpel. This results in thinning of the superior flap without compromising the vascular bed. The thinned superior flap can then be easily draped over the pedicle the create the desired size breast mound without any tension on the suture line.

RESULTS: Massive reductions could be achieved in all cases to create aesthetically appealing breast mounds. Suture line dehiscence occurred only in one case. Fat necrosis was noted in two cases which did not require any intervention. All patients were happy about the amount of reduction achieved.

CONCLUSIONS: Filleting of the superior flap helps to further reduce the bulk in massive breast reductions without putting additional tension on the suture line. The technique is easy to execute and does not compromise the vascularity of the superior flap.

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5:20 pm **Role of Liposuction in Huge Breasts**
VIMAL MALIK, MD

OBJECTIVES: Women with heavier breasts often face a lot of physical and mental trauma due to their social unacceptability. Mastopexy, which is the most common procedure for this correction, is often not preferred as the procedure can leave a lot of scars on the skin. The objective of the study is to see if liposuction can be used as a better alternative and if the results achieved are better than mastopexy.

METHODS: Heavy breasted females were divided in 3 groups.

1st group contained young women within early 20s with virginal hypertrophy or well formed big breast causing them pain in neck and back or embarrassment due to bigger size.

2nd group contained females who had sagging heavy breast post-delivery while 3rd group contained peri menopausal women with very heavy breast.

Standard liposuction was performed under local or general anesthesia using standard solution, and suctioning was performed in deeper places in the upper quadrant of breast as well as into the auxiliary space around each breast. Post operating heavy dressing was followed by proper corsets.

RESULTS: Incidentally in all heavy breasted females it is the heavy weight and pull of gravity which causes pain and embarrassment. Another finding in such cases was that as soon as the areola regains its normal wrinkles and contractions is the best time to stop suctioning as it yielded the best cosmetic results. As the result of liposuction both the objectives were achieved there was immediate change in shape of breast and it had receded back to the chest around inframammary region. This resulted in change of breast size by 2 to 3 cups.

CONCLUSIONS: Liposuction is a better alternative than mastopexy in cases of huge breasts.

5:30 pm **Sessions Adjourn**

7:00 pm **Webster Society and Cosmetic Surgery Foundation Gala Dinner (ticketed event)**

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SATURDAY, JANUARY 30, 2010

THE ART OF RHINOPLASTY AND FAT TRANSFERS

SCHEDULE-AT-A-GLANCE

7:00 am – 12:00 pm	**Registration Open**
7:00 am – 8:30 am	**Bright Eye Sessions: 301**
8:30 am – 12:00 pm	**Exhibits Open**
8:30 am – 9:15 am	**Continental Breakfast in Exhibit Hall**
9:15 am – 12:00 pm	**General Session: 302 – Lasers, Fillers and Rhinoplasty**
11:20 am	**2010 Webster Lecturer**
12:20 pm	**AACS Membership Meeting: Presidential Address and Elections**
1:00 pm	**Session Adjourn**
2:00 pm – 3:00 pm	**Practice Management Session: 303**
3:00 pm – 4:00 pm	**Practice Management Session: 304**
6:00 pm – 10:00 pm	**26th Annual Meeting Concluding Party**

SATURDAY, JANUARY 30, 2010

7:00 – 8:30 am BRIGHT EYE SESSIONS: 301
(Sessions will run concurrently)

BREAKOUT #1

Location: Wekiwa 1&2

The Art of Upper Face and Eyelid Rejuvenation

Susan M. Hughes, MD and Angelo Cuzalina, MD, DDS

The eyebrow region and eyelids can be one of the most emotional parts of anyone's face. Rejuvenating the upper facial third can be dramatic. Also, aesthetic concerns in the upper face and eyelids often affect young and middle age adults as well as the older population. The challenge is in accessing each patient to determine who may really benefit from any procedure. The endoscopic brow lift was developed nearly 16 years ago and is considered by many as the gold standard when dealing with brow ptosis and a normal hairline. However, open brow lifting using an open trichophytic approach has had resurgence in popularity and can be an invaluable technique when properly performed on the appropriately selected individuals. Both techniques offer a dramatic effect when used to specifically elevate and correct lateral brow hooding. The indications and details of each procedure along with an anatomic reviewed will be addressed by each author. In addition, specific upper and lower eyelid cosmetic surgical procedures will be reviewed in detail to include basic blepharoplasties as

well as soft tissue augmentation and skin resurfacing procedures. Comparisons between full CO2 laser and fractionated CO2 (fraxel repair) and fractionated erbium (sciton Joule) lasers will also be reviewed. Critical assessment of the upper face and eyelids is mandatory for results with minimal complications and will be reviewed by the authors. Treatment options for complications and preventative measures will also be discussed.

BREAKOUT #2

Location: Wekiwa 3&4

Avelar Abdominoplasty "A Safe Technique?"

Robert F. Jackson, MD and Chris A. Lowery, DO

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.

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BREAKOUT #3

Location: Wekiwa 5

Does Your Office Need a Risk Makeover?
Joyce Bruce, RN, MSN, JD, CPHRM

1. Evaluate key processes and practices in the cosmetic surgery practice that may create a risk of potential claims.

2. Identify best practices and implementation strategies that may reduce or eliminate the potential for claims.

3. Review and discuss case scenarios in which implementation of best practices may have avoided or mitigated the claim.

Feedback on current audience practice through participation. Evaluation of key patient flow and care processes including marketing, referrals screening, intake, informed consent, patient education, pre- and post-op care and follow-up with identification of risk issues at each point of care and identification of best practices to eliminate or mitigate the risk of claims.

Evaluation of a cosmetic surgery practice can identify potential risk issues at each critical juncture of the patient's care and provide opportunities for implementing best practices and strategies to reduce the risk of claims.

BREAKOUT #4

Location: Wekiwa 7&8

Physician Partnerships, "The Good, The Bad and The Ugly"
Dana Fox

This topic is so critical for any doctor bringing in a partner or a considering joining a practice. We see more practices in crisis over partnership issues than almost anything else. I have taught this course for other organizations for over 6 years and it gets more complex every year. As the stakes get higher and the cost of doing business skyrockets practices must look at new ways of structuring their business models. In general, the core issues almost always sift out the same: power and control, ego and economics, employees and spouses in the office.

This course is not intended to provide all the answers; for that you will need an attorney, an accountant and a great therapist!

What you will come away with is game plan for identifying your needs as a physician in private practice, or if you were looking for a new home, what type of environment would you thrive in, multiple specialty group, two-man practice, or are you better off solo?

A Few of Discussion Points:

- How do you know that you need a partner?

- Are you looking at a partnership to fund your retirement?
- Must everything be based on performance?
- If things don't work out, who gets what?
- How restrictive is a "Restrictive Covenant"?
- What happens when spouses are involved? Who's my boss?
- How is pay determined?
- Who has the authority to hire and fire?
- What's a good contract? Your attorney or mine?

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

NOTES

9:15 am – 12:00 pm General Session 302: Lasers, Fillers and Rhinoplasty

Moderators: GERALD G. EDDS, MD AND ANTHONY J. GEROULIS, MD

9:15 am **Dermamatrix Allograft in Rhinoplasty Surgery: A Viable Material to Improve Long-term Dorsal and Tip Contour and Aesthetics**
JEFFREY RAVAL, MD

BACKGROUND & OBJECTIVE: Achieving a smooth contour and symmetry along the nasal dorsum and nasal tip is one of the most difficult aspects of rhinoplasty surgery. The thin skin especially along the rhinion and nasal tip has provided an especially difficult challenge for the rhinoplasty surgeon. During the first few months postoperatively, the nose usually appears smooth and symmetric. However, once the initial swelling subsides after 6-12 months, asymmetries and minor deformities usually appear. Various materials such as cartilage and fascia have been used. In recent years artificial and cadaveric material such as Medpor and Alloderm have been described with less than optimal longterm effects.

METHOD: Retrospective review. The author describes his personal experience with over 300 rhinoplasties, primary and revision, over the last 4 years using Dermamatrix, a cadeverically derived acellular dermal collagen graft.

RESULTS: Dermamatrix acellular dermal matrix provided improved contour and symmetry over the nasal dorsum and nasal tip. The Dermamatrix graft was especially useful in providing a smoother contour over the rhinion where the skin is usually thin. In addition, using Dermamatrix over nasal tip grafts such as cap and shield grafts was especially helpful in improving symmetry. However, here is some resorption of the dermal matrix and it is therefore not an ideal material for augmentation.

CONCLUSION: Dermamatrix allograft is a useful acellular dermal matrix for improving contour and symmetry in rhinoplasty surgery.

9:25 am **The Long Double Columellar Strut – Optimizing Rhinoplasty Tip Techniques**
MARK BERMAN, MD

OBJECTIVES: The author will examine a tip technique he developed and is not commonly known. This technique is consistent, easily reproducible and has utility in almost any kind of nasal tip deformity. It allows for natural results, allowing one to correct very difficult tip irregularities including the wide bulbous tip, the under projected tip and the drooping tip.

METHODS: The author will demonstrate the method for performing the long double columellar strut combined with the suture fixation of the domes. The long double

columellar strut is contructed from septal or auricular cartilage that is cut in half and glued or sutured together. By doing this, a straight laminate is formed. This strut is placed between the medial crura and the domes are sutured to it. As such, it helps maintain straight tip support while preventing pinching and occasional downward rotation that can happen with domal suturing alone.

RESULTS: In all but 3 cases out of 245 over the last 15 years, good tip projection was maintained. There have been no incidences of infection, though mild erythema and edema is common. 8 patients underwent revision surgery – 3 for additional tip projection, the others for mild dorsal irregularities.

CONCLUSIONS: The long double columellar strut combined with the double dome suture technique provides a good technique to consistently repair tip deformities – particularly wide tips, drooping tips and tips with poor projection.

NOTES

9:35 am **Combined Endonasal and Open Rhinoplasty**
STEVEN B. HOPPING, MD

OBJECTIVES: There are many effective techniques in rhinoplasty but only a limited number of approaches. Most surgeons choose only one approach for each rhinoplasty patient (i.e. open or closed). This paper explores the principle of using multiple approaches in rhinoplasty. Specifically, combining endonasal intracartilaginous and open trancolumellar approaches.

METHODS: The indications for this combined approach include 1) the tension nose where caudal septal shortening in indicated, 2) acute caudel septal deviations or fractures, 3) overly projected nose requiring retrodisplacment, 4) initial endonasal approach requiring better nasal tip exposure, 5) revision rhinoplasties. The potential advantages and disadvantages of using a combined endonasal, open approach in rhinoplasty are discussed. These include 1) less nasal tip skin undermining, 2) less post-op tip edema, 3) hematoma avoidance afforded by drainage of the dorsal space via the intracartilaginous incisions, 4) ability to directly suture the tip cartilages and tip grafts. The conceptual rationale and technical details of the combined procedure are outlined.

RESULTS: Representative results of the combined endonasal, open rhinoplasty are reviewed and critiqued. Video demonstration of the technical aspects on the procedure will be shown to better communicate the combined approach.

CONCLUSIONS: The author concludes that the combined endonasal, open approach rhinoplasty has merit and can be useful to the rhinoplastic surgeon. The approach should be considered in certain rhinoplasty cases and it behooves the cosmetic surgeon to be knowledgeable of this procedure.

9:45 am **Hidden Pitfalls in Tip Rhinoplasty and Solutions**
GRANT S. HAMILTON III, MD

OBJECTIVES: At the end of the course, participants should be able to identify the common pitfalls in tip rhinoplasty and their solutions.

METHODS: Tip rhinoplasty can often be a vexing problem. With improved diagnostic skills, more predictable results are achievable. This course will emphasize frequently overlooked problems in the lower third of the nose and their solutions. These will include cephalically malpositioned lateral crura, sagitally malpositioned lateral crura, pollybeak deformities and short medial crura, and the over-reduced, thick-skinned nose.

RESULTS: Various techniques for treating common pitfalls will be explained with diagrams and photos.

CONCLUSIONS: By emphasizing accurate diagnosis, many post-operative problems in rhinoplasty can be prevented.

9:55 am **The Rhinoplasty Surgeon Never Graduates: Evolution and Perspectives**

M. EUGENE TARDY, MD
FEATURED SPEAKER

OBJECTIVES: Lifelong learning and analysis refinement characterize the successful Rhinoplasty surgeon, who religiously refines and modifies his techniques based on experience and an undeterred quest for new information. Since the anatomic variations in noses are essentially limitless, surgical success is predicated on exacting analysis of nasal variant anatomy. The objective of this presentation is to set guidelines for constant learning in Rhinoplasty techniques.

METHODS: Long-term Rhinoplasty outcomes and their analysis form the basis for this presentation and thesis. Carefully observing and documenting the evolutionary and constantly changing outcomes over time allow the surgeon to modify his philosophy and techniques to solve difficult nasal problems.

RESULTS: Appearance changes in the nose following Rhinoplasty continue to occur throughout the lifetime of the patient. Certain anatomic differences define the potential for excellent long-term outcomes. Analyzing these variants both before and following the surgical modification enhances the surgeon's capabilities and results.

CONCLUSIONS: Longitudinal evaluation of the evolving Rhinoplasty outcome over time (10 years or more) will refine the logic employed by the surgeon in creating natural outcomes, and assists in avoiding the unnatural result. In this sense then, the Rhinoplasty surgeon "never graduates", but rather constantly and consistently modifies his work based on a constant flow of new information and learning.

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10:25 am **A Single-Center, Retrospective Study of Long-term Efficacy and Patient Satisfaction Following Gluteoplasty Using Fat Autograft Muscle Injections**

MELANIE D. PALM, MD

OBJECTIVES: Gluteoplasty using fat autograft muscle injections (FAMI) has become an increasingly popular procedure over the last two decades. It is used to correct deformities of the buttocks as well as for aesthetic enhancement of the treated area. Currently, few retrospective studies exist on the efficacy and safety of gluteoplasty using the FAMI technique. Purportedly, fat transferred into the intramuscular compartment has increased longevity due to the highly vascular environment. This may enhance the long-term results of gluteoplasty performed in this manner. The primary objective of this study is to evaluate the effectiveness and patient satisfaction of gluteoplasty utilizing the FAMI technique. The secondary objective is to evaluate the presence of post-operative complications and frequency of adverse events following this procedure.

METHODS: Patients having undergone gluteoplasty via fat autograft muscle injections (FAMI) were identified. Patient charts were reviewed by a physician for demographic information as well as parameters related to the procedure including volume of fat transferred, type of fat transferred, and length of follow-up. Patients returned to clinic for photographic documentation of long-term results and were evaluated by the treating physician. In addition, patients completed a subjective questionnaire regarding their satisfaction with the procedure, postoperative adverse events (including pain, bruising, and surface irregularities), and duration of response to gluteoplasty.

RESULTS: At the time of abstract submission, the study is nearing completion. Twenty-three patients, aged 27-61 years of age underwent gluteoplasty using the FAMI technique. Length of follow-up after procedure ranged from 3-100 months. Only 2 patients out of the cohort used frozen fat, the rest were transferred with fresh adipose tissue. An average of 83 cc of fat was transferred to patients in the first augmentation procedure. 4 patients had at least one additional FAMI procedure. Adverse events including bruising and pain were mild in the majority of patients; only one patient reported moderate bruising; another patient reported moderate pain; all others reported no to mild bruising or pain. No post-operative complications were reported. Most patients reported results for at least 1-2 years; in many cases this was the duration of follow-up time. Greater than 80% of patients would recommend the procedure to a friend. Final results will be presented at the AACS meeting.

CONCLUSIONS: Gluteoplasty using the FAMI technique is a safe and effective procedure for buttock augmentation. Its long-term results appear to be durable and patient satisfaction is high.

10:30 am **Lipostructuring of the Aging Hand**
AYMAN HELMI, MD

OBJECTIVES: Aging hand is part of the generalized aging process. It is not getting much attention compared to the other body parts. I noticed a "face-hand age mismatch" in patients who undergo facial aesthetic procedures when the hand is not rejuvenated. Rejuvenation of the hand should is part of the totla aesthetic care.

METHODS: 32 patients underwent rejuvenation of the hand by lipostructuring with minimal incision using a long malleable cannula.

RESULTS: All patients were very happy with the outcome that matches well with their body features and age.

CONCLUSIONS: Rejuvenation of the aging hand by lipofilling through a minimal incision is a safe procedure done under local anesthesia on outpatient basis.

NOTES

10:35 am **Measured Vacuum Pressures with the Various Harvesting Devices During Autologous Fat Grafting**
RONALD D. SHIPPERT, MD

OBJECTIVES: Most surgeons agree that increased pressures will damage the fat during harvest. Those that use the Closed Syringe Technique assume that the pressures are quite low, but most do not know what pressures exist in the syringe at any given level of filling.

MATERIALS & METHODS: Vacuum pressures were measured on several syringes (60 cc, 30 cc and 10 cc) that are customarily used for the Closed Syringe Technique. The setup was quite simple with the product being tested connected to a vacuum pressure meter. Measurements were taken with the device empty and other levels of filling.

RESULTS: The 60 cc syringes produced 18.5 inches of Mercury pressure when empty, 16 inches when one half full and 14 inches of Mercury when 2/3 full. The 30 cc syringes produced 16, 13 and 10 inches of Mercury and the 10 cc syringes measured 10, 6 and 3 inches of Mercury.

DISCUSSION/CONCLUSIONS: The vacuum pressure possible within a syringe depends directly on the volume of open space, thus a 60 cc syringe will allow 18.5 inches of pressure when empty and only 16 inches when one half empty and 14 when 1/3 empty. Most investigators say that the ideal pressure for lessened fat cell trauma is 15 to 20 inches of Mercury, and that this method fulfills that criteria. The tests also indicate that for the 30 and the 10 cc syringe the pressure is an acceptable low for protection of the lipocyte, but lowered pressures below 15 will slow the harvest considerably.

10:40 am **Structural and Endoscopic Comparison of SAL, WAL, UAL, PAL, LAL**
AFSCHIN FATEMI, MD

OBJECTIVES: There are different ways to do liposuction, just by suction (SAL), power assisted (PAL), by Waterjet (WAL), by ultrasound (UAL), laser assisted lipolysis (LAL).

But how does the tissue look like after impact with the different canullas, is there a safer way to do liposuction?

METHODS: Cadavers were treated with different techniques, the effect on the tissues, especially on the fat cells and on the septal fibers were analyzed. Abdominoplasty patients were treated and the tissues analyzed the same way. The tissues were analyzed by direct comparison after different ways of liposuction, by endoscopy and in open surgery and the corresponding clinical results. The specific complications of each type of liposuction were analyzed. In an additional histological study, septal fibers and fat cells were analyzed.

RESULTS: There were clear differences between the different kinds of liposuction. The specific complications were mostly due to the effects of the canulla to the septal fibres and the dermis.

CONCLUSIONS: Certain aesthetic and medical complications after liposuction can be correlated to certain types of liposuction.

NOTES

10:45 am **Autologous Grafting of Vaser Emulsified Fat**

ROBERT J. SCHWARTZ, MD

OBJECTIVES: Autologous fat has been used for breast and body augmentation procedures for many years. Ultrasound emulsified fat has been rarely used due to an erroneous belief that the ultrasound-induced cavitation lyses the cells rendering them non-viable. In fact, ultrasound energy waves cause rapid expansion and contraction of microbubbles in the tumescent fluid. The volume changes in the bubbles cleave intercellular bonds freeing small groups of fat cells to form the emulsion. Fat cell viability is well-preserved. We have used VASER ultrasound emulsified fat for body augmentation since 2008.

METHODS: VASER ultrasonic liposuction was performed on 11 patients (1 male and 10 females) between 26 and 60 years of age. Areas contoured were abdomen, hips, flanks, thighs, and back. The one and two ring 3.7 mm probes and the three ring 2.9 mm probes were used. Power was set at the lowest level that would permit easy passage of the VASER probe. This was generally 50-70%. VASER mode (pulsed) was used in all cases. Fat was suctioned with 3.0 mm and 3.7 mm Vent-X cannulas and was collected into a Shippert Mega Tissu-Trans device. Gravity separation occurred within the device and the separated fat was drawn directly into 20 mL syringes. The fat was injected into the recipient areas through a Shippert 3 mm injection cannula. The areas injected were buttocks (6), breasts (3), thighs (1), and hips (1). All patients were placed in a compression garment for 2-4 weeks.

RESULTS: The VASER emulsified fat was easier to handle than conventionally aspirated fat. The small particles and emulsion consistency made it easier to draw into syringes using less vacuum pressure on the plunger. Clogging and "sticking" of the fat while drawing into the syringe were virtually non-existent. The use of the Shippert Tissu-Trans system simplified fat collection and processing eliminating the need for centrifuging, additional syringe transfers, and air exposure. Surgery times were shorter. Injection of the emulsified fat required less syringe pressure giving the surgeon more precise control over injected fat volumes. Lower syringe pressure also made it easier to inject small amounts of fat with each cannula pass. All patients achieved meaningful augmentation of the treated areas as confirmed by follow-up examination at three months or more. There were no complications.

CONCLUSION: Recent investigation has shown that ultrasound produces volume oscillations in microbubbles dissolved in tumescent fluid and these fluctuations cleave the fat cells to form an emulsion. Ultrasound-induced lysis of fat cells occurs far less often than was believed. To whatever degree fat cell lysis is occurring, its effect on fat graft viability may be offset by other desirable characteristics of the VASER emulsion. VASER treated fat flows more easily, so it is subjected to smaller vacuum pressure and shear forces as it is drawn into syringes and then injected. Its greater fluidity makes it easier to inject controlled small amounts of fat enhancing revascularization and graft survival.

10:50 am **Are Your Liposuction Cannulas and Handle-Cannulas a Potential Problem if Used for Autologous Fat Graft/Transfer?**
RONALD D. SHIPPERT, MD

OBJECTIVES: Performing Autologous Fat Grafting involves several steps that can lead to contamination of the graft. To outline this problem attention usually turns to steps in the procedure that expose the graft to ambient air, multiple transfers and the centrifuge. To date there has been little investigation and papers on the inner pathway of the fat graft through the handles, cannulas and such. The speaker examined the pathway of the fat grafts through the liposuction instruments presently being used for fat grafting.

MATERIALS & METHODS: Most of the popular brands of Liposuction Handles and Cannulas that are presently being used for both Liposuction and AFG were examined by cutting them longitudinally with a metal saw. This gave a view of the pathway of the fat through the handle, the cannula and the attached fixtures that has never been seen before.

RESULTS: Most of the handles examined had "crevices and dropoffs" and most cannulas had "blind pockets" in their tips. These areas can harbor debris from previous cases and are extremely difficult (and sometimes impossible) to clean by standard means. All of these deformities can be prevented by a change in the initial construction of the device.

DISCUSSION & CONCLUSIONS: Although it seems logical for the surgeon to economize by using Liposuction instruments for the harvesting of fat for grafting, the chance of encountering instruments with inner deformities is high. The risk can be lessened by the using instruments that have been constructed specifically for AFG as well as those constructed for one-time use. To prevent deformities in the handles, it is important for the stainless steel cannula to lie the entire length of the handle. To prevent blind pockets in the cannulas, it is important for the first and distal hole be placed in a manner that it does not leave a blind pocket in the tip.

NOTES

10:55 am **Use of Macrolane, a New Hyaluronic Acid to Reshape Body Contour**
BEATRICE LAFARGE CLAOUE, MD

OBJECTIVES: We use a specific hyaluronic acid to increase volume and reshape the body to correct defect after liposculpture, to correct ptosis and increase volume of the breast another indication is buttock augmentation and reshaping specially with patient which did not want implants. We will demonstrate that it is a safe and easy procedure, a good alternative of fat grafting.

METHODS: 30 patients were treated with macrolane, technique of injection of buttock and breast will be described under local anesthesia. The way to use VRF 20 and VRF 30 syringes, the quantity of hyaluronic acid injected is between 100 and 200 cc.

RESULTS: 90% of patients are happy with the procedure, no side effect but some redness and pain especially with buttock augmentation, 50% of patient ask for more with a second injection after one year, the result stays about 18 months.

CONCLUSIONS: Hyaluronic acid for big volume to reshape body contour seems a good alternative for patient when fat grafting is not possible due to too skinny patient or to correct small defect (after liposculpture).

11:05 am **No-Incision Earlobe Rejuvenation**
TANUJ NAKRA, MD

OBJECTIVES: Aging changes of the earlobe include loss of skin elasticity, volume loss, and descent. Surgical maneuvers to improve the earlobe can be effective but do not address volume loss and the resultant descent. Autologous fat transfer is an effective treatment for age-related volume loss of the face. We describe the use of fat transfer techniques to treat the age related volume loss and descent of the lobule.

METHODS: A retrospective analysis was performed on patients who underwent autologous fat transfer to the lobule from July 1, 2007 to June 15, 2009. Abdominal and lateral thigh fat were used as donor fat harvest sites. Gravitational decanting was used to isolate the fat, and the fat was transferred to 1cc syringes and injected using the Tulip disposable canula system. Fat was transferred to the earlobes. Pre- and postoperative photos were reviewed for efficacy of rejuvenation. Postoperative complications were reviewed.

RESULTS: A total of 34 patients were identified who underwent autologous fat transfer to the lobules in the specified period. The vast majority of patients had notable improvement in the lobule volume and descent. Pre- and postoperative photographs will be presented to demonstrate the benefits of this procedure.

CONCLUSIONS: Autologous fat transfer to the lobules is a safe and minimally-invasive procedure that addresses the primary cause of aging of the lobule. The maneuver requires minimal surgical time and results in long-lasting natural rejuvenation of the lobule.

NOTES

11:10 am **An Argument for the Routine Harvesting and Storage of Adipose Derived Adult Stem and Regenerative Cells (ADASRC's) Utilizing Water Assisted Liposuction (WAL)**

TODD K. MALAN, MD

Adipose tissue is now recognized as an important source of postnatal mesenchymal stem and stromal cells[1]. Lipoaspirate from liposuction specimens yield 1000 times more stem cells than a comparable volume of bone marrow aspirate[2]. These Adipose Derived Adult Stem and Regenerative Cells (ADASRC's) have many exciting emerging clinical applications. Human studies utilizing ADASRC's have demonstrated a significant improvement in chronic wound healing, as an effective scaffold for bone and cartilage remodeling, and as a means of enhancing autologous fat graft survival[2]. Preclinical animal studies have demonstrated significant tissue regenerative capacity in post myocardial or renal infarction models and large-scale trials in humans are currently underway to evaluate improvement in cardiac function in post myocardial infarction and chronic heart failure patients. The potential future applications of ADASRC's for tissue engineering and regenerative tissue techniques are limitless. The ability to obtain quality lipoaspirate specimens, the fractionation of ADASRC's, and the storage techniques are readily available to clinicians utilizing off the shelf technology and commercially available services.

In this presentation I will discuss these emerging technologies and techniques and describe our experience in obtaining high yield lipoaspirate tissue sample utilizing the Body-Jet™ (Eclipse Medical, Dallas, TX) WAL device. In addition I will discuss our experience utilizing the Stem Source™ device by Cytori Inc. (San Diego, CA) to process WAL harvested fat for the purpose of obtaining graft specimen enhanced with ADASRC's. A cost effective and clinically feasible solution for the routine storage of ADASRC's enriched adipose tissue for future cosmetic as well as tissue engineering and regenerative applications will also be discussed in detail. Study data presentation to include: WAL obtained fat graft viability analysis, ADASRC's tissue yield, and storage viability.

REFERENCES:

1. Zuk PA, et al: Human adipose tissue is a source of multipotent stem cells. Mol Biol Cell 2002;13:4279-95.

2. Strem BM, Hedrick MH. The growing importance of fat in regenerative medicine. Trends Biotechnol 2005;23:64-6.

11:20 am **Dealing with the Difficult Patient**
HOWARD A. TOBIN, MD
2010 WEBSTER LECTURER

My decision in 1982 to limit my practice to cosmetic surgery resulted largely from the influence of Dr. Richard Webster. Traveling together through China on a teaching mission, we began a friendship that grew with the years. He was a constant source of inspiration for me as well as many of my colleagues. Dr. Webster also taught me that the way in which you deal with patients is just as important as your clinical acumen and surgical skill. While it is easy to deal with most of our patients who are generally appreciative of our efforts, sometimes the doctor patient relationship can be a challenge. Interacting with the difficult patient demands all the skills and efforts of the surgeon and his staff. This talk will deal with ways of avoiding the potentially difficult patient and positively relating to those that you treat. The effort begins with the initial consultation and extends through the patient's surgery and postoperative care. In addition we will use this opportunity to remember Dr. Webster and reflect on some his goals and aspirations for the continued growth and success of the Academy.

NOTES

11:50 am The First U.S. Face Transplant: From the Laboratory to the Operating Room

MARIA SIEMIONOW, MD, PHD
FEATURED SPEAKER

OBJECTIVES: 20 years of experience with composite tissue allograft models is presented. First, the experimental models of microcirculatory response to ischemia and reperfusion injury and surgical trauma are discussed, with presentation of the intravital microscopy system for direct in vivo observation of the microcirculation of the composite tissue allograft transplants. The intravital microscopy system presents responses to hemodynamic changes, leukocyte endothelial interactions, and permeability of the grafts under different ischemic conditions and under the trauma of transplantation surgery.

METHODS: These studies served as a baseline for establishment of treatment protocols for composite tissue allograft transplants. As a result, the meticulous surgical techniques and shortening of ischemia time and reperfusion injury, were considered in development of the experimental models for composite tissue transplantation.

RESULTS: The model of rat hind limb transplantation, across major histocompatibility barrier, is presented as a standard model for evaluation of graft rejection, and for testing of tolerance induction, under different immunosuppression and immunomodulation protocols. The outcome of the treatment protocols for induction of tolerance and chimerism is discussed. The evolution of composite tissue allograft models from limb transplantation to groin transplantation and face transplantation, is discussed.

The models of full face transplantation, hemi-face transplantation, and composite facial-cranial, and facial-maxilla transplantation, are presented with different immunosuppression protocols.[1]

Finally, in preparation for face transplantation, cadaver studies evaluating the technical feasibility of a full face transplant and evaluation of the surface area for face and scalp transplantation, are discussed. [2,3]

CONCLUSIONS: These 20 years of research in the field of composite tissue allograft transplantation are presented as the basis for the first IRB approval for facial allograft transplantation in humans, leading to the first face transplantation surgery performed in the United States, in December 2008.

REFERENCES:

1. Siemionow M, Gozel-Ulusal B, Engin Ulusal A, Ozmen S, Izycki D, Zins JE. Functional tolerance following face transplantation in the rat. Transplantation. 2003 May 15;75(9): 1067-9.

2. Siemionow M, Unal S, Agaoglu G, Sari A. A cadaver study in preparation for facial allograft transplantation in humans: part I. What are alternative sources for total facial defect coverage? Plast Reconstr Surg. 2006 Mar; 117(3):864-72; discussion 873-5.

3. Siemionow M, Agaoglu G, Unal S. A cadaver study in preparation for facial allograft transplantation in humans: part II. Mock facial transplantation. Plast Reconstr Surg. 2006 Mar;117(3):876-85; discussion 886-8.

12:20 pm AACS Membership Meeting: Presidential Address and Elections

12:50 pm Cosmetic Surgery Foundation Presentation

1:00 pm Sessions Adjourn

NOTES

2:00 – 3:00 pm Practice Management Sessions: 303
(Sessions will run concurrently)

BREAKOUT #1

Location: Wekiwa 1&2

Secrets of the Internet Revealed

Eva Sheie

Internet marketing is the most important marketing service of all, yet doctors waste hard-earned funds on a daily basis by simply not understanding how patients research and shop online. This course is for the beginner to intermediate web marketing practice: You have a website and you understand it must be marketed. You've dabbled with inclusionary and directory listings and now you want to improve your ranking and visibility. You'd like help sifting through all of the "technical mumbo jumbo" and take away information you can use when you get home.

- What is meant by SEO (search engine optimization) and SEM (search engine marketing) and how much they should cost.
- How UEO (user experience optimization) works and how is it different from SEO.
- 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.

Web Extortion – Are You At Risk? (Special segment for all levels of practice.) Scams targeting cosmetic surgeons are on the rise, and the bad guys are getting better at it all the time. In this course, you'll learn about the most common scams perpetrated on doctors through the Internet, and how to prevent these dangerous online predators from damaging you. Learn to spot and prevent these scams from happening to you:

- Domain name theft.
- Extortion by false practice website.
- Phony web partners offering to trade links.
- Unethical social engineers posing as reputable sources for web marketing.
- Hidden text dropped into your site by unethical web marketers.

- Armed with some simple steps, you will be able to better prevent these damaging outcomes to your reputation and practice.

BREAKOUT #2

Location: Wekiwa 3&4

Navigating the Landmines from the Risks of Electronic Communications
Joyce Bruce, RN, MSN, JD, CPHRM

1. Identify specific risks from electronic communication including email, websites, EMRs, PHRs.

2. Review regulatory and legal considerations for practices in implementing electronic communications.

3. Discuss the policies, procedures and interventions needed to comply with regulations impacting electronic communication.

Feedback on current audience practice through participation. Identification of how recent government regulations and amendments impacting electronic communication require changes in a practice's administrative, privacy and security safeguards Recent ARRA amendments require practices to review and revise how they manage electronic communication to ensure compliance.

NOTES

BREAKOUT #3

Location: Wekiwa 5

Asset Protection, Tax and Exit Strategies for Today's Surgeons
David B. Mandell, JD, MBA

Increase the well-being of surgeons through education of planning alternatives they have but may not yet understand. Alleviate the stress surgeons experience in practice by providing concrete techniques for making their personal and practice assets more secure.

This presentation identifies the pros and cons of each type of legal entity for a medical practice and helps surgeons understand why multiple entities may be desirable, to differentiate among various types of retirement plans, to comprehend the benefits of captive insurance arrangements and to review the alternatives to self-funded exit strategies.

Surgeons are at high risk for liability, both as physicians and employers. Understand what asset protection planning means in practice and personally, identify opportunities in their own situation to employ tactics for shielding practice assets, such as accounts receivable, or personal assets, like retirement plans, real estate, investments and others.

BREAKOUT #4

Location: Wekiwa 7&8

Don't Let Your Med Spa be "Dead Spa"
Susan Browner

In an effort to increase profits and to expand their patient base, doctors all over the country opened "Med Spas." Now we're seeing train wrecks everywhere as surgical revenues were traded for minimally invasive procedures and injectables revenue. Yes, it may look easy but you need to look at a Med Spa for what it is – a business demanding accountability, performance and profitability goals.

Discussion points:

- Leading your practice to the promised land post-Recession.
- Decide where you want to be: this year, in 3 years, in 5 years.
- Thinking about adding a Med Spa? Evaluate your current practice and decide if the Med Spa approach is right for you and your practice – now or as a pathway to your future.
- Already have a Med Spa? Thinking about expanding? What you need to consider before expanding.

Let's do some business planning and consider:

- Physical plant.
- Preempt your competition.

- Be the media expert in your region.
- Harness the latest technology (Web, Internet, Blogging, Social Media).
- Selecting services and products to be offered: skin care; laser and minimally invasive cosmetic procedures; injectables; surgical consults; bundle products and services to win long term patient loyalty.
- Converting entry level services into high ticket surgeries.
- Find the best staff to represent you.
- Spa employees – training, compensating and caring for them.
- Integrate spa employees with your existing staff.
- Build the elective surgical side of your practice.
- Using job descriptions, non-disclosures, employee contracts and restrictive covenants.
- Responding proactively to ups and downs in the economy – a closing look at how some of our nation's largest retailers have responded.

NOTES

3:00 – 4:00 pm Practice Management Sessions: 304 (sessions will run concurrently)

BREAKOUT #1

Location: Wekiwa 1&2

Captive Insurance/Alternative Risk Planning for the Cosmetic Surgeon

Stewart A. Feldman, JD

This presentation will address the advantages of alternative risk/captive planning, including lowering insurance costs, enhancing control over cash flows and investments, improving risk management and loss control, and realizing tax efficient asset protection and wealth transfer. The parameters of implementing a well-structured captive insurance program will be considered. Finally, situations where the profits of the insurance vehicle can be loaned back to the operating company and/or distributed to the captive ownership will be explained.

This presentation provides an overview of the key aspects – insurance, regulatory, financial, and corporate and tax – of captive insurance/alternative risk planning. The discussion is directed to physicians who have ownership interest in a closely held company (an ASC, for example).

Key topics discussed:

What is a captive insurance company? A captive insurance company is a company established to insure the risks principally of affiliated businesses. Captives in various forms have been around for hundreds of years; there are an estimated 6,000 captives operating. The ownership of the captive may mirror the ownership of the business or may be owned by a subset of the owners of the operating company or by the junior generation.

Why form a captive?

1. To protect your business from the many hidden risks inherent in its operations. Conventional policies cover only a portion of the potentially insurable risks faced by a business.

2. Clients come to understand that a wide range of risks faced by their business are otherwise capable of being insured with tax deductible premiums, even when paid to an affiliated insurance company.

3. Significant advantages exist for pre-funding losses through a captive insurance company.

4. Closely-held businesses create captives to achieve financial benefits that come from favorably loss experience and the resulting build-up of monies in the captive, which can then be distributed to the captive's owners in the case of favorable loss experience.

Criteria For captive planning? Generally only businesses and their owners with a minimum of $1 million/year in taxable income should consider this planning.

Historically, businesses have managed exposures to risk by purchasing a conventional insurance policy that transfers the risk to the insurer, or by retaining the risk and allocating funds to pay the eventual losses. Many businesses are including the benefits of alternative risk funding techniques, such as captive planning, in the overall risk management process. Among the reasons for doing so are the practical difficulties in collecting from the insurer when the loss occurs, the extensive use by insurers of exclusions and limitations on coverage buried in the policy, and the implied threat of non-renewal when a loss is reported. In addition, closely held business are creating captives to achieve wealth building and wealth transfer goals.

NOTES

BREAKOUT #2

Location: Wekiwa 3&4

Price Transparency in Cosmetic Surgery and its Impact in a Struggling Economy

Abhishek Chatterjee, MD

With the present U.S. economic decline linked to the United States housing bubble that peaked in early 2005 and burst soon thereafter leading to an economic recession as declared by the National Bureau of Economic Research in December of 2007, many cosmetic practices are facing the burden of providing services to patients who are spending less. In cosmetic surgery, most cosmetic procedures lie in the category of fee for service and hence the free market. Price transparency is present to patients in a fee for service market since they have access to procedure fee schedules. On the other hand, procedures such as reduction mammoplasty are often reimbursed by third party insurance payers; thus, price transparency to the patient for these procedures is significantly less and patients often provide only the co-payment. Our goal was to analyze recent trends regarding specific fee for service cosmetic procedures versus a cosmetic procedure reimbursed by third party insurance payers to test if the lack of price transparency creates a difference in demand during periods of economic turmoil.

We studied the database of a tertiary care hospital in which the plastic surgery department did a significant majority of the cosmetic cases. We looked at yearly and quarterly case volumes for injectibles, augmentation mammoplasty procedures, and reduction mammoplasty procedures between the fiscal years 2004 and 2008 to determine trends. We then used Spearman's Rho (correlation coefficient) analysis for quarterly case volumes on each of the three procedures during this time period and tested for statistical significance.

Fiscal yearly trends from 2004 to 2008 showed an increase in overall injectibles from 41 procedures to 123 procedures. Similar yearly trend analysis showed a decrease in augmentation mammoplasty procedures from 34 to 18 and a decrease in reduction mammoplasty procedures from 301 to 227. When analyzing quarterly trends, injectibles had a correlation coefficient of 0.73 with a p-value = 0.0003 showing that as the years progressed there was a statistically significant positive association with a rise in the demand for injectibles. When analyzing augmentation mammoplasty, the correlation coefficient was -0.35 with a p-value = 0.132. This indicated a small negative association that was not statistically significant between the time period studied and demand for augmentation mammoplasty. Lastly, when studying reduction mammoplasty, the correlation coefficient was -0.57 with a p-value of 0.008 indicating a negative association that was statistically significant between the time period studied and demand for reduction mammoplasty.

Our analysis does not support the hypothesis that a lack of price transparency created by third party insurance payers buffers against a struggling economy. Specifically, our data

shows that in a recession, demand in a tertiary care health center had decreased over the observed time period for both augmentation and reduction mammoplasty procedures. Surprisingly, demand for low cost, fee for service injectibles increased in demand during the observed time period.

BREAKOUT #3

Location: Wekiwa 5

Is Your Staff Your Secret Weapon or Your Greatest Weakness?
Dana Fox

- There has never been a more critical time than today to have staff that is absolutely stellar. As we secret shop practices nationwide every month, it is amazing how many practices lose valuable opportunities at the beginning of the process because no one is minding the store. 85% of the secret shopper calls we make reveal practices miss the mark 9 times out of 10 when it comes to closing the deal.

Discussion points:

- Apply what Nordstrom and Ritz Carlton use as a strategy for hiring the right people.
- Learn the best process for closing the "sale". Realize greater success with a strategic follow-up process.
- Implement new methods for inspiring your staff and creating "stakeholders".
- Determine your accountably for what's working and what's not.

The average practice works much harder than they need to, churning through patients they don't close or who are inappropriate in the first place. They wear themselves out and then look at empty slots in their surgery schedule, knowing in their heart of hearts those patients had surgery somewhere else. In this economy you cannot afford to make very many mistakes and survive. The buck stops with you!

NOTES

BREAKOUT #4

Location: Wekiwa 7&8

Publicity and Practice Marketing
Angela O'Mara

An economic recovery is underway and how you meet the challenges of this new economy can make, or break, your practice. The old adage of "when the going gets tough, the tough get going" couldn't be more appropriate than today. In this new era, the savvy cosmetic surgeon will realize that there are many new and different marketing methods to embrace that will increase their visibility. However, there also remain many tried and true techniques that are still effective and should not be forgotten.

Cosmetic surgery patients are consumers that shop. Billionaire Warren Buffet says it well, "Price is what you pay. Value is what you get." How are you distinguishing your practice from the competition? Who is your competition? What are you doing to create consumer awareness of your surgical techniques, professional skills, experience and services? Are you able to convince the public to make you their number one choice when it comes to cosmetic surgery?

This session will help you:

- Create a "value"-driven practice.
- Learn how to develop your own media.
- See the pros and cons of social networking via the internet.
- Develop and build your "brand" effectively.
- Spend advertising dollars wisely.
- Make your staff "team" players.
- And much more.

This session is based on current "real life" economic strategies and over 20+ years of experience marketing highly successful practices. Using a combination of new ideas and classic techniques, you will leave with the knowledge to begin a successful reinvention of your own practice.

6:00 – 10:00 pm **26th Annual Meeting Concluding Party**
ROSEN SHINGLE CREEK RESORT
BUTLER ROOM

NOTES

SUNDAY, JANUARY 31, 2010

THE ART OF COSMETIC FILLERS, SKIN TREATMENTS

SCHEDULE-AT-A-GLANCE

7:00 am – 12:00 pm	**Registration Open**
7:00 am – 8:30 am	**Bright Eye Sessions: 401**
8:30 am – 9:15 am	**Continental Breakfast**
9:15 am – 12:15 pm	**General Session: 402 – Fillers and New Technologies**
12:15 pm	**Meeting Adjourns**

SUNDAY, JANUARY 31,2010

7:00 – 8:30 am BRIGHT EYE SESSIONS: 401
(Sessions will run concurrently)

BREAKOUT #1

Location: Wekiwa 1&2

The Art of Abdominoplasty – Traditional vs. Avelar

E. Antonio Mangubat, MD and Michael H. Rosenberg, MD

Information not available at press time.

BREAKOUT #2

Location: Wekiwa 3&4

Hair Restoration Surgery

Marco Barusco, MD

The objective of this session is to utilize the time allotted to provide participants with an informal, "seminar-like" experience that will focus on reviewing important concepts in the field of hair restoration surgery. Novice and experienced surgeons alike will benefit from this discussion.

An initial, short overview presentation will be followed by an open forum and live consultation. I will have available a video-microscope and all equipment necessary to provide participants with a complete consultation, during which we will discuss aspects such as patient selection, evaluation of current and future hair loss, hair miniaturization, patophysiology of Androgenetic Alopecia in men and women, medical treatment options, surgical planning, surgical execution and expected results.

For experienced hair restoration surgeons, this will be a perfect opportunity to share their experience with the group. For plastic and cosmetic surgeons who do not currently practice the specialty of hair restoration surgery, this session will give them the tools they need to discuss this procedure with their clients, and perhaps introduce it in their practices.

BREAKOUT #3

Location: Wekiwa 5

Innovations for Fat Transfer

Mel Bircoll, MD

My origination of the procedure of Fat Transfer using Liposuction techniques in the early 1980s is discussed including a brief description of the basics of the technique. More recent modifications of the original "Bircoll Technique" and their relevance to today's practice are presented. My concept of Fat Storage in liquid nitrogen and the use of this stored adipose tissue with serial Fat Transfer injections creates the foundation for successful and optimal results with autologous tissue transfer. The stored fat is used for cosmetic surgery (breast enlargement, facial enhancement, hand rejuvenation), a wide range of reconstructive surgery and stem cell extraction.

BREAKOUT #4

Location: Wekiwa 7&8

Lessons from the Trenches: Marketing Your Cosmetic Practice

Mark K. Mandell-Brown, MD

With current economic times, it is essential for the cosmetic surgeon to make every marketing dollar count. Dr. Mark Mandell-Brown will share effective marketing strategies to help you build and maintain your practice. The attendee will learn effective techniques to brand your practice and review marketing tips that have worked as well as those that haven't.

Analysis of marketing expenses and patient sources will be discussed. The internet and word of mouth are the two largest referral sources. Identifying your referral sources and continually monitoring your marketing campaign are essential for a successful cosmetic practice.

The session should provide the attendee with knowledge to successfully initiate or maintain a marketing campaign for a cosmetic surgeon.

NOTES

8:30 – 9:15 am Continental Breakfast

9:15 am – 12:15 pm General Session 402: Fillers and New Technologies

Moderators: NEIL S. SADICK, MD AND SUZAN OBAGI, MD

9:15 am **Use of Artefill for the Treatment of HIV Lipoatrophy**
JOSEPH A. EVIATAR, MD

OBJECTIVES: Filler injections in the periorbital and mid-face region have been shown to be an excellent solution for the treatment of HIV lipoatrophy. Most injectable fillers are a temporary solution for these patients. Artefill, a PMMA and purified bovine collagen mixture, used for HIV lipoatrophy, provides a more long lasting and equally aesthetic alternative. The objective of the study was to evaluate the safety and effectiveness of soft tissue augmentation of the permanent filler, Artefill, in patients with facial lipoatrophy secondary to HIV disease.

METHODS: A retrospective chart review examines eleven patients injected with Artefill, a filler composed of 20% PMMA microspheres and 80% purified bovine collagen injected into deep dermis and just subcutaneously for improvement of facial contour, to treat HIV facial lipoatrophy. These eleven patients received the Artefill injections for HIV lipoatrophy in a private practice in New York City over a six-month time period. Each patient's atrophic appearance was graded on a scale of one to four based on post treatment photographs by the same two observers. The primary endpoint of the study was to evaluate the effectiveness of the correction of facial lipoatrophy by comparing changes from baseline using the Global Aesthetic Improvement Scale (GAIS) with confirmation using standardized photography. According to the scale each patient's atrophic appearance was graded as follows: 1=mild, 2=deeper, but not wide spread, 3=deeper, but wider spread, 4=severe. Treatments were done in two month intervals until full correction was achieved.

RESULTS: Of the eleven patients in whom the Artefill was used, two patients graded 1-2, two patients graded 2, two patients graded 3, one patient graded 3-4 and two patients graded 4. Three of these patients had been treated with Sculptra in the past. Six patients had previously had Radiesse. One patient had Newfill and Radiesse previously. One patient has cheek implants. All eleven patients had improvement after treatment with Artefill.

CONCLUSIONS: Artefill offers a more long-term, effective and well-tolerated treatment for patients with facial lipoatrophy. This new soft tissue filler material demonstrates an excellent safety profile, with a more permanent effective solution for necessary soft tissue augmentation. For

physicians wishing to achieve a more permanent, long-lasting result Artefill is an alternative to other temporary fillers available, with very high patient satisfaction.

9:25 am **Treatment of Surgical Scars at Time of Wound Closure with Fractional CO2 Laser**
DAVID M. OZOG, MD

OBJECTIVES: To determine if fractional CO2 laser treatment on surgical sites at time of initial surgery can prevent scarring.

METHODS: Split scar study where half of surgical sites are treated with fractional CO2 laser while the other half used as control. Scars evaluated at six weeks and three months by blinded evaluators.

RESULTS: Eight of ten scars were improved on the treated side versus the non-treated. No complications were seen.

CONCLUSIONS: Fractional CO2 laser may have use at time of surgery for scar prevention.

NOTES

9:35 am **An Open-label, Split-face Study Comparing the Safety and Efficacy of Levulan Kerastick (Aminolevulonic Acid) Plus a 532nm KTP Laser to a 532nm KTP Laser Alone for the Treatment of Moderate Facial Acne**
NEIL S. SADICK, MD

OBJECTIVES: Recent advances in light therapy coupled with photosensitizes offer alternatives to topical creams and gels and systemic oral agents for acne treatment. To examine the safety and efficacy of the photosensitize 5-aminolevulinic acid (ALA) in patients with moderate-to-severe acne, a randomized, split-face study, using ALA on one side of the face, was followed by exposure of the entire face to 532 nm potassium titanyl phosphate (KTP) laser.

METHODS: Eight patients completed three treatments for up to 12 weeks.

RESULTS: The average acne grading at baseline was 3.20, and improved to 2.12 at 12 weeks (34% improvement). Use of ALA improved acne by 52% compared with 32% on the side that did not receive the photosensitize.

CONCLUSIONS: Further studies are warranted to establish optimal parameters for photosensitize use combined with light therapy for treatment of moderate-to-severe acne; however, the combined use of ALA and 532 nm laser suggests promising results for acne treatment.

9:45 am **Keep it Simple: Skin Needling – A Simple Yet Effective Tool in the Treatment of Acne Scarring, Enlarged Pores, and Rhytides**
SHARLEEN ST. SURIN-LORD, MD

BACKGROUND: Skin needling has been used since 1995 to encourage percutaneous collagen induction (PCI). The technique has advanced since its inception – from the use of 15-gauge needles and tattoo needles, to the now more popular rolling micro-needles. The presenters, whose current practices in the treatment of acne scars include laser resurfacing, dermabrasion, non-ablative fractional resurfacing, also perform rhytidectomies, chemoresurfacing, and other procedures to address facial laxity. Many patients are disinclined to try the aforementioned procedures due to the downtime required and/or the risk of hyperpigmentation. In order to accommodate these patients, the presenters have adopted the use of skin needling.

OBJECTIVE: The purpose of this abstract is to report the efficacy of PCI via skin needling in the treatment of acne scarring in three patients as well as facial laxity and rhytides in one of these three patients. Of these patients, two also have a history of post-inflammatory hyperpigmentation (PIH).

METHODS: Photographs were taken in direct and indirect lighting prior to treatments. Patients underwent micro-needling using 2-mm micro-rollers and discharged

with written skincare instructions. Photographs were taken at one-month follow-up appointments.

RESULTS: Percutaneous collagen induction with the 2-mm micro-needle roller was efficacious in treating rolling scars, as these scars became less deep after two treatments. The patient with rhytides and facial laxity experienced a decreased appearance in periorbital rhytides after one treatment. All patients experienced the benefit of pore minimization. Additionally, there were no adverse reactions, patients complained of a mild sunburn appearance for two days, after which they were able to resume their skin care regimens, which included tretinoin cream. Patients were satisfied and scheduled subsequent micro-needling sessions. The patient with rhytides and facial laxity no longer desires a rhytidectomy. Since the collagen production associated with PCI occurs for up to three months, we are monitoring these patients for further improvement.

CONCLUSION: With current use of these micro-rollers, what was once a laborious process has become a cost-efficient, effective therapy requiring very minimal downtime. This is also a very promising treatment for patients struggling with post-inflammatory/post-procedural.

NOTES

9:55 am **Tricep Augmentation: Early Experience with the Procedure**
NIKOLAS CHUGAY, MD

INTRODUCTION: In the past 10 years, there has been a noticeable increase in the number of males seeking cosmetic surgeons for enhancement of their physique, leading to the development of new and innovative techniques to meet their needs. It is in this vein that we have worked to develop a technique to further upper extremity physical enhancement. Despite hard work at the gym and good dietary habits, some male patients are unable to attain the definition and shape to their upper extremities that they desire. In order to help men achieve a more sculpted upper extremity, we have worked to develop an implant and procedure to augment the tricep muscle.

METHODS: A retrospective review of prospectively collected patient data was performed to identify appropriate study patients.

PROCEDURE: The skin is incised in the axillary region. The fascia overlying the long head of the triceps is identified and incised. The fascial incision is extended and fascial flaps are created. A custom-made triceps solid silicone prostheis is placed just beneath the fascia of the triceps muscle. Closure of the fascia is performed with a 3-0 Vicryl suture and skin is closed in subcuticular fashion using a 4-0 Vicryl suture.

RESULTS: A total of 9 cases of tricep augmentation have been performed over the past 2 years. Of those cases, there were 3 complications. 1 complication was a patient report of weakness in the hand on the operative side with noticeable difficulty in writing. This patient did not desire corrective surgery and had spontaneous resolution of his weakness. The other 2 complications were extrusions of the prosthesis from below the fascia. These were corrected by a return to the operating room for tacking of the fascia to the triceps muscle to create a tighter pocket for the implant to prevent migration.

CONCLUSION: Although relatively new, tricep augmentation is another tool available to the cosmetic surgeon to aid in providing patients with their desired physique.

10:05 am **Use of Harmonic Scalpel in Cosmetic Surgery**
MOHAN THOMAS, MD

OBJECTIVES: The harmonic scalpel has been in use in surgical practice for the last 15 years. Cosmetic and plastic surgeons have been slow to make use of this useful technique. The present documented use of this technique is for harvest of pedicled flaps like the latissimus dorsi and pectoralis major muscle flaps. In aesthetic surgical practice the harmonic scalpel has been used in surgeries for massive weight loss where it has been documented to reduce the seroma formation. We report the use of this useful technique in cosmetic surgery.

METHODS: 50 cosmetic surgery procedures were performed using the Harmonic scalpel for soft tissue dissection and elevation of flaps. The cases included 15 cases of breast reduction, 10 cases of mastopexy, 2 cases of facial reanimation, 5 cases of facial rejuvenation and 18 cases of abdominoplasty. The cases were studied with regards to ease of operation, time consumed, post operative edema and amount of post op discharge.

RESULTS: The harmonic scalpel was found to be a very useful aid in the procedures mentioned. The ease of dissection was significantly more when compared to electrocautery dissection. There was minimal post operative edema and about 50 percent reduction in fluid discharge. The time required was the same in the initial few cases and then it reduced by 20 percent. Smaller vessels get coagulated when cut with the harmonic scalpel and this reduces the blood loss and time spent in haemostasis.

CONCLUSIONS: The harmonic scalpel is a useful addition to the armementarium of the cosmetic surgeon. For a small addition in costs incurred, there is significant increase in the ease of dissection, reduced blood loss, post operative edema and discharge.

NOTES

10:15 am **New Techniques in Facial Hair Transplantation**
MARCO N. BARUSCO, MD

OBJECTIVES: To discuss new and updated techniques for transplanting hair to the eyebrows, eyelashes and the beard/mustache.

IMPORTANCE & RELEVANCE: One of the most exciting advancements in the specialty of hair restoration is the ability we now have of transplanting hair in virtually any area of the body. Besides the obvious scalp, other common recipient areas include the eyebrows, the beard/mustache and the eyelashes.

With the evolution of the techniques and use of follicular units, the addition of hair to areas of the face became possible. However, transplanting hair into the eyebrows, eyelashes and the beard/mustache is tricky, and the transplant surgeon needs to have experience and knowledge of facial anatomy, normal hair angle, distribution and direction, in order to create a natural result for the patient.

Much can be accomplished with make-up and tattoos. A patient who either has genetically thin eyebrows or who has lost them due to years of plucking and waxing can resort to such cosmetic options in order to restore the framing to their eyes. The same can be done with eyelashes.

The one critical problem with the use of eyebrow pencils, eyeliners or tattoos is that, although they add framing to the eyes, they do not provide the visual sensation of depth. Only hair can restore the depth and tri-dimensional effect that natural eyebrows and eyelashes have. When done well, surgical restoration of the eyebrows, eyelashes and beard can have dramatic effects on one's appearance and confidence.

During the lecture I will discuss in detail the nuances in technique for each particular area, before and after pictures and actual surgery footage will be used to illustrate the key points of the lecture.

10:25 am **Homeopathic Arnica Montana for Bruising: Does it Work? (funded by an individual research grant from The Cosmetic Surgery Foundation)**
BRETT S. KOTLUS, MD

OBJECTIVES: The use of homeopathic Arnica Montana, a flowering herb, has been widely advocated for the reduction of ecchymosis after surgery. We evaluate its efficacy after upper eyelid blepharoplasty.

METHODS: A prospective, placebo-controlled, double-blind study was performed in which 30 patients were randomly assigned to the administration of homeopathic A. Montana or placebo concurrent with unilateral upper eyelid blepharoplasty followed by contralateral treatment at least one month later. Ecchymosis was evaluated at days 3 and 7 by rank order of severity and measurement of surface area of ecchymosis.

RESULTS: There was no statistically significant difference in area of ecchymosis or rank order of ecchmosis severity for days 3 and 7 after treatment with A. Montana versus placebo. Additionally, there was no difference in ease of recovery per patient report and there was no difference in rate of ecchymosis resolution.

CONCLUSIONS: We find no evidence that homeopathic A. Montana as used in this study is beneficial in the reduction or the resolution of ecchymosis after upper eyelid blepharoplasty.

10:35 am **Judicious Use of Antibiotic Prophylaxis in Cosmetic Surgery**
ALEX DENES, MD

OBJECTIVES: Current decisions on whether or not to use antibiotic prophylaxis, and the choice of antibiotics, are largely tradition-based, and not really grounded in scientific principles. By presenting infectious disease data and experience, a case would be made for basing such decisions on evidence-based outcomes and rationale.

METHODS: Literature review.

RESULTS: Inappropriate and unnecessary utilization of antibiotics relative to cosmetic surgery is widespread. This practice promotes bacterial resistance, subjects patients to unnecessary risk of reactions and side effects, and is cost-ineffective. There is ample data to suggest that, in most clean cosmetic surgery cases, there is no need at all for antibiotic utilization. In others, where contamination may be a concern; where the operation is lengthy or involves significant blood loss; or where patients are immunocompromised, antibiotics may be justifiable. Data will be presented to suggest evidence-based criteria for selection and timing of antibiotics.

CONCLUSIONS: We, as cosmetic surgeons, should base our antibiotic-prophylaxis decisions on solid scientific data, and not rely on "tradition" or "shotgun" modalities. Patients should be risk-stratified for infection potential, and antibiotic usage and selection should be based on those criteria.

NOTES

10:45 am **Corrugator Supercilii Muscle Terminal Nerve Percutaneous Ablation for the Treatment of Hyperdinamic Vertical Glabellar Furrows**
GUILLERMO BLUGERMAN, MD

OBJECTIVES: Hyperdynamic vertical glabellar furrows (HVGF) are an aesthetic concern in the forehead. Several techniques have been applied in an attempt to eliminate HVGF. Thus, a minimally invasive procedure that can eliminate the HVGF permanently is still warranted.

Further insight of periorbital muscle distribution and innervation has allowed the development of novel techniques to reduce HVGF. The corrugator supercilii muscle is located frontally underneath the eyebrow and its contraction draws the medial end of the eyebrow downward, and wrinkles the forehead vertically, thus, generating the HVGF. We describe here a novel percutaneous technique that achieves CSMNT ablation for the treatment of HVGF.

METHODS: During the preoperative visit, the surgeon shall discuss patient's expectations, surgical results and risks. The patient should be informed that only dynamic and not static wrinkles are being treated by the procedure. Blue marks are placed bilaterally at the level of the outer canthus and the outer border of the iris.

Following adequate skin preparation, skin is infiltrated with lidocaine 1% solution with epinephrine 1:200000 throughout the subcutaneous tissue and skin immediately below the blue marks, usually 1 ml per mark suffices.

We recommend waiting for 15 to 20 minutes following infiltration in order to achieve adequate skin vasoconstriction. The procedure could be done under local anesthesia or mild sedation.

At each of the four marks, the following steps are done: 1) the guiding needle is used to punch the skin immediately above the eyebrow and will then travel deeply at the level of the supraperiostium and emerge outside the skin below the eyebrow; 2) The needle is then reentered next the second orifice (below the eyebrow) and will travel underneath the skin subdermally and will emerge outside next to the first orifice (above the eyebrow); 3) The crossed vicryl sutures surround several anatomical structures (orbicularis oculi muscle, CSMNT, blood vessels and subcutaneous tissue). These sutures are gently pulled in a sawing motion with counter tension in order to resect all anatomical structures, aiming for CSMNT ablation.

After the procedure, we apply pressure for 3-5 minutes with cool compress in an attempt to minimize oozing and hematoma formation.

RESULTS: We started using this technique in 2007 and have performed 47 bilateral procedures. In two patients unilateral ablation was performed in order to correct

facial asymmetries due to a sequel of facial paralysis, as previously reported by Nicklison and Marino.

80& of the patients were female. HVGF recurrence was 3%. Even after recurrence, complete muscle contraction was not totally recovered, thus, patient satisfaction was high.

Major complications were not observed during follow-up. Mild discomfort due to the development of local bruising at the palpebral area may ensue and may last up to two weeks.

CONCLUSIONS: We described a novel percutaneous, crossed suture, manual technique to ablate the CSMNT and successfully relaxed the HVGF. This technique is effective, safe and rather straightforward. It is the author's opinion that this novel technique may represent a simple and permanent solution for HVGF.

NOTES

10:55 am **30-Minute Procedures that Built My Practice**
SCOTT M. BLYER, MD, DDS

OBJECTIVES: To inform and educate attendees of different 30-minute procedures that have a steep learning curve and high patient satisfaction. Every patient who benefited from one of these procedures returned for other more involved surgeries.

METHODS: I will demonstrate through a PowerPoint presentation how I perform earlobe rejuvenation, lip lift, silicone lip implants, V-Y advancement of the lip, and temporal-buccal fat pad suspension. Additionally, I will demonstrate how these procedures acted as a springboard to have other procedures done.

RESULTS: Multiple cases will be shown demonstrating the procedures along with caveats of the surgeries. 10 lip lifts performed with 5 out of 5 satisfaction, 100% of the patients returned for other procedures, 8 returned for surgery, 8 referred others. 23 earlobe rejuvenation performed with 5 out of 5 satisfaction, 100% of the patients returned for other procedures, 18 returned for surgery, 23 referred others. 33 silicone lip implants performed with 5 out of 5 satisfaction, 100% of the patients returned for other procedures, 32 returned for surgery, 29 referred others. 15 V-Y lip advancements performed with 5 out of 5 satisfaction, 100% of the patients returned for other procedures, 14 returned for surgery, 14 referred others. 4 buccal fat suspension performed with 5 out of 5 satisfaction, 100% of the patients returned for other procedures, 2 returned for surgery, 1 referred others. Totals included 85 patients, with 5 out of 5 satisfaction, 100% returned for other surgery, 74/85 had other surgeries, and 75/85 referred others to my practice.

NOTE: I hope to add to this list by the time the conference arrives, not only in patient volume but additional procedures.

CONCLUSIONS: "Word of mouth" is what my mentors have preached as the best way to build a practice. How does one get that first patient in, to trickle down the "word"? I have been very successful in performing different quick, simple, and cost effective procedures with high patient acceptance and satisfaction, which has generated this elusive "word". From these procedures patients have come back for more involved surgeries, and referred their friends and family.

11:05 am **An Intra-areolar "No-Skin-Scar" Approach to Breast Augmentation**
LEONARD A. RUBINSTEIN, MD

OBJECTIVES: A unique approach to Breast Augmentation has been developed which limits the surgical incision to a natural wrinkle within the areolar tissue. This approach avoids any scarring of the skin as well as avoiding the typical complications associated with traditional breast augmentation techniques. We describe this technique and our experiences over the past 20 years.

METHODS: The intra-areolar multi-w-plasty technique of breast augmentation will be described.

RESULTS: Natural appearing results, increase ease of placement of breast implants, marked decrease in post-operative complications are all benefits of this unique intra-areolar approach to breast augmentation.

CONCLUSIONS: The intra-areolar multi-w-plasty technique provides a marked advance in breast augmentation in that complications and scarring are avoided. Furthermore, aesthetic results are improved and there is a significant increase in patient satisfaction.

11:15 am **Hetter's Modified Phenol/Croton Oil Peel: Science and Practice**
L. MIKE NAYAK, MD

OBJECTIVES: To review the science behind the Hetter modified phenol/croton oil peel, and to elucidate its clinical practice and applications.

METHODS: The scientific basis for phenol/croton oil peeling will be reviewed, as will the basic principle of ablative cutaneous resurfacing. The clinical application of the peel itself will be demonstrated via photographs and video, as will the expected postoperative healing course. Postoperative care, complications, and their management will be reviewed. Using the peel as part of a multimodal facial rejuvenation in conjunction with facelifting, blepharoplasty, browlifting, and laser resurfacing will also be addressed.

RESULTS: Several segmental and full face before and after photos will be reviewed to demonstrate the technique's applications, strengths, and weaknesses.

CONCLUSIONS: The Hetter's modified phenol/croton oil peel is a remarkably effective tool in the reduction or elimination of dermatoheliosis.

NOTES

11:25 am **Fractional CO2 Laser Resurfacing in CW Mode Approximates the Clinical Results of Traditional CO2 Resurfacing in a Single Treatment Yet Retains the Safety Advantages of Micro-Fractional Skin Resurfacing**

MARK W. KOFFORD, MD, PHD

BACKGROUND & OBJECTIVE: Fractional technology in skin rejuvenation devices range from the ablative Erbium, to the thermal RF, with Superpulse CO2, Ultrapulse CO2, and Continuous Wave (CW) CO2 in between. All systems have been used effectively to rejuvenate skin with reduced risk of side effects over traditional complete epidermal ablation. A study was undertaken using a CW CO2 with millisecond domain pulse widths (2.5ms – 16ms) to establish depth of tissue ablation and width of residual thermal damage (RTD). A concurrent study was also done using the same laser to assess degree of cosmetic improvement and to determine if using a CO2 laser in CW mode at high energy with wide pulse widths would result in a marked increase in patient downtime or increase in adverse side effects.

MATERIALS & METHODS: Ex-vivo human and pig skin were prepared in normal saline then non-sequentially scanned with an 180µm spot at a 20% coverage. Pulse energy was studied over a range of 100-1800J/cm^2 at pulse widths of 2.5ms, 3.5ms, 5ms, 8ms, 12ms, and 16ms. Twelve patients (skin types II – IV) with medium to severe rhytids or acne scars (from 45 to 67 years of age) were selected for the study. All subjects received a single facial treatment using a micro-fractional Continuous Wave CO2 laser with a 180 µm spot non-sequential scanner. A variety of power settings were used as clinically indicated. Subjects were evaluated for improvement in dyschromia, skin tightness, scar and wrinkle reduction at day 7, 3 months and 6 months post-treatment.

RESULTS: Histology revealed an increase in tissue depth of ablation as power (W) was increased (10W, 20W, 30W settings with a constant pulse width of 2.5ms). Notably, histology demonstrated a proportional decrease in ablation depth while increase in RTD with an increase in pulse width (2.5ms, 5ms, 8ms 12ms, 16ms). There was no histological evidence of thermal bleed between scanned spots even at spot energy greater than 1,500J/cm^2. All patients were judged to have moderate to excellent degree of cosmetic improvement. Time to complete epithelial recovery was 4-7 days in all cases, including high energy and high coverage cases.

CONCLUSIONS: Maximum temporal separation of sequentially scanned spots is required in high energy fractional CO2 resurfacing to retain the safety advantages and rapid recovery. Pulse durations of greater than can be used to selectively deliver a greater proportion of pulse energy as RTD vs. ablation to precise skin depths. Treatment depth and proportion of ablation vs. RTD can be more precisely manipulated by instruments that give the physician independent control of both pulse width and pulse energy. The art of facial resurfacing has always been, and remains, the

clinical application of the correct proportion of ablation vs. RTD at the correct tissue depth. Instruments which enable the trained clinician to target tissue by manipulating these factors independently will result in the best and safest outcomes.

NOTES

11:35 am **An Analysis of the Long-Term Safety Data of Repeat Administrations of BoNT-A for the Treatment of Glabellar Lines**
IRA LAWRENCE, MD

BACKGROUND: A new US botulinum neurotoxin type A formulation (BoNT-A; Dysport™ [abobotulinumtoxinA]; Medicis Aesthetics Inc., Scottsdale, AZ) has recently been approved by the US Food and Drug Administration for the treatment of moderate to severe glabellar lines.

OBJECTIVE: The primary objective of this study is to assess the long-term safety of repeat administrations of BoNT-A in the treatment of glabellar lines, including the long-term safety of variable dosing based on gender and muscle mass.

METHODS: This report summarizes an interim analysis of an open-label extension study following 1414 subjects who underwent retreatment with BoNT-A during a 24-month period after completing at least 1 of 4 Phase 3 BoNT-A studies. Patients were re-treated with either 50 U of BoNT-A or a variable dose of 50, 60, 70, or 80 U of BoNT-A based on muscle mass. The dose was divided among 5 injection points in the glabellar region. No subject received more than 8 treatments of 50 U during this 24-month analysis or 4 treatments with variable dosing. Patients were followed at 7, 14, and 30 days after each injection, then monthly until re-treatment, study completion, or early termination. Endpoints for this repeat administration phase were adverse events (AEs) and vital sign changes.

RESULTS: Of the 1414 patients, 856 (61%) experienced at least 1 AE. The incidence of AEs in patients in the variable dose groups (depending on dose and gender) was comparable to that of patients in the fixed-dose groups. Most reported treatment-emergent AEs (TEAEs) were mild (72%) or moderate (19%); 5% of TEAEs were rated as severe. All but 3 severe TEAEs, and the majority (86%; 2727 of 3167) of all TEAEs, were considered not related or unlikely related to the study treatment. One serious AE in 1 patient (mild eyelid ptosis) was judged probably related to treatment. Another (myasthenia gravis in the immediate vicinity of the eye) was judged possibly related to treatment. The overall incidence of TEAEs and related events remained constant or decreased over repeat cycles. The most frequently reported AEs were nasopharyngitis (12%), headache (7%), upper respiratory tract infection (6%), and sinusitis (6%). No clinically significant mean changes from baseline vital signs were observed. The most commonly reported AEs around the eyes were eyelid ptosis (2% of patients), eyelid edema (1%), and dry eye (1%). A total of 40 ptosis events were reported in 37 patients; none was judged severe, and nearly half resolved within 3 weeks. The number of ptosis events reported declined with successive cycles. The incidence of ocular events overall and ptosis specifically did not appear to be dose related.

CONCLUSIONS: Multiple cycles of treatment with fixed (50 U) or variable (50 to 80 U) dosing of BoNT-A are well tolerated. There was no evidence of cumulative safety issues, since the incidence of AEs remained relatively constant or decreased over repeated treatment cycles.

NOTES

11:45 am **Maximizing Treatment of the Aging Face with Cosmeceuticals**
JENNIFER LINDER, MD

OBJECTIVES: Patients frequently seek recommendations for the most effective age control skin care products. As physicians our patients expect us to be aware of topical ingredients currently available and their actual ability to improve the skin.

METHODS: Review the structural breakdown that occurs as a result of the intrinsic and extrinsic aging process and identify scientifically proven topical ingredients which effectively correct current and prevent future damage.

RESULTS: This comprehensive overview focuses on many different cosmeceutical ingredients and their specific mechanism of action. These include retinoids, ascorbic acid, melanogenisis inhibitors, peptides and antioxidants. Retinoids are able to reduce corneocyte cohesion, regulate collagenase activity, reduce melanosomal phagocytosis and encourage the synthesis of collagen, elastin, glycosaminoglycan and fibronectin. Ascorbic acid offers fibroblast-stimulating properties to produce collagen, reduction of matrix metalloproteinase production, tyrosinase inhibition and anti-inflammatory capabilities. Peptides are at the forefront of topical anti-aging treatments and, while several types are available, the collagen-building and neurotransmission-inhibiting benefits are the most compelling and substantiated. Antioxidants are also imperative to the improvement of visible aging and by identifying the individual characteristics of ingredients such as resveratrol, vitamin E, epigallocatechin gallate and silymarin beneficial blends can be selected for optimal protection. Increase the formation and distribution of collagen, inhibit the melanogenesis process and prevent the cellular oxidation and inflammation that accelerates visible aging using multiple components that have shown to be safe and effective for topical use.

CONCLUSIONS: Topical therapies allow the surgeon to correct superficial imperfections and enhance the results of more invasive procedures. The identification of the most multi-faceted and beneficial ingredients will assist in determining the efficacy of currently available skin care products. Confidently recommending products that contain ingredients that provide consistent results will deepen the physician-patient relationship and your practice's bottom line.

11:55 pm **Gums Depigmentation: Surgical Enhancement of Gingival Aesthetics**
AVADHESH R. BHARDWAJ, MD

OBJECTIVE: To make the person beautiful and smile with confidence. In this we change the blackish brown gummy smile into a "Pinkish Brilliant Smile".

PROCEDURE: It can be done by four ways: 1) Partial thickness flap removal (epithelial excision); 2) Bur abrasion; 3) Electrosurgery; 4) Laser.

CONCLUSION: By this procedure we enhance the beauty of the face by removing the blackish gums and make the white teeth mach with gums. With bright brilliant teeth the healthy pink gums are always a complement.

RESULT: Gums depigmentation is based on removal of melanin pigments by various surgical procedures and gives a stunning smile on face.

For a stunning smile cosmetic appearance of teeth and gums goes hand in hand. With bright brilliant teeth the healthy pink gums are always a complement. A smile expresses a feeling of success, affection and courtesy, and enhances self confidence and gives the feeling of kindness. The harmony of the smile depends upon the shape of the teeth, color of the teeth, position of the teeth, but it is also important to have a healthy gingival tissue with pink color.

Gingival health and appearance are essential components of an attractive smile. Gingival color depends upon the pigmentation which is a result of melanin granules. Melanin granules are produced by melanoblasts. The more melanoblastic activity the more is the pigmentation. Melanin pigmentation of the gingiva is completely benign and does not present a medical problem.

The basic complaint is of "blackish brownish gums". In patients those who are having high smile line it is very much visible and called "Gummy Smile". For depigmentation of gingiva different treatment modalities have been reported like partial thickness flap removal (epithelial excision), bur abrasion, electrosurgery and laser. In these cases we have done all four techniques partial thickness flap (epithelial excision), bur abrasion, electrosurgery and laser for depigmentation, which are simple, effective and produced good results, which has given a complete satisfaction to the patient. As every coin has two sides, each technique has some limitations also. The limitation of each techniques is also been discussed.

12:15 pm **Meeting Adjourns**

NOTES

EXHIBITOR DESCRIPTIONS

A TO Z SURGICAL

Booth #: 500 & 502
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Hauppauge, NY 11788
E-mail: kenny@georgetiemann.com
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Phone: 800.843.6266
Fax: 631.273.6199
Product Category: Surgical Instruments

Surgical instruments and accessories for HT and office-based surgery.

AAAHC

Booth #: 403
Contact: Alison Solway
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Skokie, IL 60077
E-mail: asolway@aaahc.org
Website: www.aaahc.org
Phone: 847.853.6060
Fax: 847.853.9028
Product Category: Associations

The Accreditation Association for Ambulatory Health Care (AAAHC/Accreditation Association), founded in 1979, is the leader in ambulatory health care accreditation with over 4,600 organizations accredited nationwide. AAAHC accredits a variety of ambulatory health care organizations including ambulatory surgery centers, office-based surgery centers, student health centers, and large medical and dental group practices.

AART

Booth #: 406
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Website: www.aartinc.net
Phone: 775.853.6800
Fax: 775.853.6805
Product Category: Clothing, Implants, Surgical Instruments, Other Medical Equipment

AART, Inc. is an innovative, full-service global supplier to the cosmetic, plastic, and reconstructive therapies. AART provides a complete range of premier implants and accessories for facial and body contouring, including customs. AART's compression garments address every need. The Dimisil™ Scar Management System continues to lead in technology and efficacy.

ADVANCED BIO-TECHNOLOGIES, INC

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Product Category: Cosmetics, Pharmaceutical

ALLERGAN

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Product Category: Pharmaceuticals

Allergan Medical, a division of Allergan, Inc., offers the most comprehensive, science-based, aesthetic product offerings under its Total Facial Rejuvenation™ portfolio, including BOTOX® Cosmetic; hyaluronic acid and collagen-based dermal fillers; LATISSE® (bimatoprost ophthalmic solution) 0.03%; and physician-dispensed skin care products. Allergan Medical also offers the industry's widest range of silicone gel-filled and saline-filled breast implant options for reconstructive and aesthetic breast surgery, and leading minimally invasive devices for obesity intervention treatment.

ANTHONY PRODUCTS/GIO PELLE

Booth #: 100, 102, 104, 106, 108
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Indianapolis, IN 46226
E-mail: api@anthonyproducts.com
Website: www.anthonyproducts.com
Phone: 800.428.1610
Fax: 317.543.3289
Product Category: Cosmetics, Implants, Surgical Instruments

For 40 years, Anthony Products has specialized in the distribution of ENT, Plastic Surgery and Dermatology instruments and equipment. Gio Pelle specializes in customized skincare and microdermabrasion. Gio Pelle offers personalized gel packs for post-procedure recovery. Private label opportunities are available.

APOTHÉCURE

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Fax: 972.960.6921
Product Category: Pharmaceuticals

ApothéCure is a premier compounding pharmacy offering a wide array of compounding in the areas of aesthetic and functional medicine. Some of our compounds include: mesotherapy, dermatology, micro-needling, general aesthetics and anti-aging, weight loss, natural hormones, chelation, nutritional and much more. For more information, please call us or visit our website.

ASSI – ACCURATE SURGICAL

Booth #: 210
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Phone: 800.645.3569
Fax: 516.997.4948
Product Category: Surgical Instruments

ASSI offers the Perma Tunneler & Forceps, Ear Lobe Clamp, Ceramic Coated SuperCut Scissors, Stanger C®, Engler Breast & Facelift Retractors, Endoscopes, DiGeronimo Fill Tube Inserter Clamp, "Cookie Cutters", Breast Dissectors, Lalonde® Breast Sizers, Breast Reduction Compression Device, Campbell Lip Awl, Micro Monopolar Hand-switching Forceps, Lipo Roller, Microdissection Needles, Bipolar Scissors, StaySharp® SuperCut Facelift Scissors, Klapper Breast Surgery SuperCut Scissors & Lalonde® Skin Hook Forceps for Blepharoplasty.

AXIS THREE

Booth #: 135
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E-mail: aliciarecupero@axisthree.com
Website: www.axisthree.com
Phone: 617.273.8496
Fax: 617.273.8498
Product Category: Computer Hardware & Software, Imaging & Photographic Equipment

Axis Three is the leader in 3D surgical simulation. By integrating image capture technology, developed by Siemens, with its own innovative software – Portrait 3D – Axis Three delivers a paradigm shift in medical imaging: precise surface anatomy capture, breakthrough simulation technology, interactive photo-quality 3D models, and powerful tools for planning a surgery. Axis Three's Portrait 3D delivers a return on investment quickly with increased consultations and conversions and an enhanced patient experience.

BIODERMIS

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Phone: 702.260.4466
Fax: 702.260.4646
Product Category: Cosmetics

As the originators of the scar management industry, we offer the most comprehensive line of Epi-Derm silicone gel sheeting, Xeragel silicone ointment, and our latest innovation Pro-Sil silicone stick applicator. We also provide the industry leading compression foam product, Epi-Foam.

BIOFORM MEDICAL

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Fax: 866.862.1212
Product Category: Other – Dermal Filler

BioForm Medical, Inc. is a worldwide medical aesthetics company focused on developing and commercializing products that are used by physicians to enhance a patient's appearance. Its core product is Radiesse® dermal filler. FDA approved for long lasting wrinkle correction, Radiesse provides a safe and cost-effective aesthetic enhancement for patients.

BLACK & BLACK SURGICAL

Booth #: 533
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Phone: 770.414.4880
Fax: 770.414.4879
Product Category: Cosmetics & Skin Care, Surgical Instruments

Black & Black Surgical is a fill line aesthetic plastic and reconstructive surgical instrument company, featuring Tebbetts instruments for rhinoplasty and breast surgery. Other products include Endoscopic equipment and instruments. We also feature second-to-none Stille® SuperCut scissors and NexEdge® Rasp and Osteotomes, plus a unique line of anti-aging skin care products by Corina™ featuring an FDA-approved delivery system.

BLINC

Booth #: 421
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Product Category: Cosmetics & Skin Care

CAMELOT MEDICAL

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Website: www.camelotmedical.com
Phone: 201.339.3996
Fax: 201.339.3997
Product Category: Surgical Instruments

Camelot Medical was founded on the premise that the acquisition of the right equipment, devices and supplies for the performance of cosmetic procedures is not inherently a do-it-yourself process. A smart cosmetic surgeon and cosmetogynecologist need to find quality vendors who are reliable and who can also offer superior service and support.

CANDACE CROWE DESIGN

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Fax: 877.384.7677
Product Category: Patient Education, Practice Management

Candace Crowe Design has delivered patients for plastic surgeons since 1999. REVENEZ, our suite of expert marketing tools, includes educational videos for your website, customizable waiting room loops, patient education CDs for the consult, and e-campaigns. We complete your brand with web design, search engine optimization, brochures, ads, and folders.

CANDELA CORPORATION

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Product Category: Lasers

Since 1970, Candela has helped launch and grow more aesthetic practices than any other laser company in the world. Whether starting a practice or looking to expand an existing one, Candela has the most comprehensive and technologically advanced portfolio of lasers for today's popular applications; hair removal, skin rejuvenation, skin tightening, wrinkles, vascular and pigmented lesions and tattoo removal. Today, we continue to lead the way, developing ways to help practices like yours thrive.

CANFIELD IMAGING SYSTEMS

Booth #: 426
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Fax: 973.276.0339
Product Category: Computer Hardware & Software, Imaging & Photographic Equipment

Canfield Imaging Systems is the leading worldwide developer of imaging software and photographic systems for the medical and skin care industries. Product lines include Mirror® imaging software, VISIA® Complexion Analysis, VECTRA® 3D Systems, Reveal® facial imagers, customized photographic studio solutions and numerous specialized imaging devices and lighting systems for clinical photography.

CARE CREDIT

Booth #: 507
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Website: www.carecredit.com
Phone: 714.434.4127
Fax: 866.874.4093
Product Category: Financing

CareCredit, a division of GE Money, is the nation's largest patient finance company serving over 100,000 healthcare practices and 7 million patients.

CARE-TECH® LABORATORIES, INC

Booth #: 425
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Fax: 314.772.4613
Product Category: Pharmaceuticals

CARE-TECH® manufactures non-toxic, broad spectrum antiseptic technology in the form of surgical prep and scrub. We also provide topical antiseptics for the prevention of topical wounds. MRSA effective with simple daily bathing procedures or surgical site maintenance. MRSA effective! Our new adjunct for laser procedures "Humatrix®" is eliciting very positive results. Stop by for samples.

CHASEHEALTHADVANCE

Booth #: 517
Contact: Lisa McIntyre
Address: 1717 Hermitage Blvd.
Tallahassee, FL 32308
E-mail: healthcarefinancing@chase.com
Website: www.chasehealthadvance.com
Phone: 888.388.7633
Fax: 866.758.7633
Product Category: Financing

ChaseHealthAdvance makes it easy for your patients to finance the treatment they need. Increase treatment acceptance with 12, 18 & 24 Month No Interest Payment Plans and credit lines starting at $5000.

CONTOURMD MARKETING

Booth #: 411
Contact: Margie Elliott
Address: 8055 Bond
Lenexa, KS 66214
E-mail: margiee@contourmd.com
Website: www.contourmd.com
Phone: 800.683.3826
Fax: 913.541.0380
Product Category: Garments & Clothing

ContourMD has conveniently combined the best of Post Surgical Compression Garments and Marketing Services for your practice. Contour® compression garments are manufactured from the highest quality Lycra-Spandex fabric, allowing your patients to Recover in Comfort™. Our Affiliate Partner Marketing Program offers the opportunity for additional revenue for your practice.

COOK MEDICAL

Booth #: 208
Contact: Jennifer Moore
Address: 750 Daniels Way, PO Box 489
Bloomington, IN 47402-0589
E-mail: info@cookmedical.com
Website: www.cookmedical.com
Phone: 800.458.4500
Fax: 800.554.8335
Product Category: Implants, Other
Medical Equipment & Supplies

Provide your patients new or restored confidence. Biodesign™ (Surgisis®) is a widely used advanced tissue repair material now available for plastic and reconstructive procedures, including nipple and breast reconstruction, remodeling of soft facial tissue and facial volume restoration. Biodesign's inherent growth factors signal the body's cells to remodel the graft into fully vascularized tissue. Cook Medical—Advancing the aesthetics of tissue repair.

COOLTOUCH

Booth #: 217
Contact: Elwood Phillips
Address: 9085 Foothills Blvd.
Roseville, CA 95747
E-mail: info@cooltouch.com
Website: www.cooltouch.com
Phone: 916.677.1900
Fax: 916.677.1901
Product Category: Lasers & Laser Supplies

CoolTouch, founded in 1996, is a leading U.S.-based developer and manufacturer of innovative, advanced laser products for medical professionals. The 25 watt CoolLipo Trio™ 1320 nm laser system combines three procedures into one laser platform; laser-assisted lipolysis/skin tightening, endovenous ablation and non-ablative skin rejuvenation.

COSMETIC SURGERY TIMES

Booth #: 514
Contact: Amy Ammon
Address: Cosmetic Surgery Times/Dermatology Times
485F US Highway 1 South, Suite 100
Iselin, NJ 08830
E-mail: aammon@advanstar.com
Website: www.cosmeticsurgerytimes.com
Phone: 732.596.0276
Fax: 732.596.0016
Product Category: Publishing

Cosmetic Surgery Times facilitates the exchange of ideas among aesthetic disciplines, reporting the credible, relevant, timely information that shapes the practices of its physician and surgeon readers. Focused on the cosmetic nature of plastic and dermatologic surgery practices, covering relevant aesthetic developments from an interdisciplinary perspective that includes the subspecialties of laser surgery, hair restoration, maxillofacial surgery and ocular plastic surgery.

CUTERA

Booth #: 522
Contact: Pam Faaland
Address: 3240 Bayshore Blvd.
Brisbane, CA 94005
E-mail: pfaaland@cutera.com
Website: www.cutera.com
Phone: 415.657.5515
Fax: 415.330.2444
Product Category: Lasers & Laser Supplies

CYNOSURE, INC

Booth #: 200, 202
Contact: Dawn Frick
Address: 5 Carlisle Rd.
Westford, MA 01886
E-mail: info@cynosure.com
Website: www.cynosure.com
Phone: 978.256.4200
Fax: 978.256.6556
Product Category: Lasers & Laser Supplies

Cynosure, Inc. develops and markets aesthetic treatment systems that are used by physicians and other practitioners to perform non-invasive and minimally invasive procedures to remove hair, treat vascular and pigmented lesions, rejuvenate the skin, liquefy and remove unwanted fat through laser lipolysis and temporarily reduce the appearance of cellulite.

DEKA MEDICAL, INC

Booth #: 412
Contact: Kristina Cranias
Address: 665 Third Street #20
San Francisco, CA 94107
E-mail: info@dekamedinc.com
Website: www.dekalaser.com
Phone: 650.367.8108
Fax: 415.358.8800
Product Category: Lasers & Laser Supplies

ECLIPSE

Booth #: 321
Contact: Michelle Peters
Address: 16850 Dallas Pkwy.
Dallas, TX 75248
E-mail: mpeters@eclipsemed.com
Website: www.eclipsemed.com
Phone: 800.759.6876
Fax: 972.380.2953
Product Category: Lasers

Eclipse is a leading supplier of aesthetic high-tech medical devices. Eclipse proudly offers Body-Jet water-jet assisted liposuction, EndyMed PRO with 3DEEP, SmoothCool HR/SR and many other leading aesthetic solutions. With over 15 years of experience, Eclipse delivers best-in-class aesthetic solutions to build and transform practices.

ELLMAN INTERNATIONAL, INC

Booth #: 207
Contact: Ilene Strobing
Address: 3333 Royal Ave.
Oceanside, NY 11572
E-mail: ilene@ellman.com
Website: www.ellman.com
Phone: 800.835.5355
Fax: 516.569.0054
Product Category: Other Medical Equipment & Supplies

Ellman International, a worldwide leader and manufacturer of high frequency radiosurgical equipment, presents the Surgitron IEC Dual Frequency. This device utilizes 4.0 MHz for cut, blend, and coag. Bipolar utilizes 1.7 MHz. It provides pressureless incisions with minimal tissue alteration, superior biopsy specimens and excellent cosmetic results. Please visit our booth for a demonstration on how radiosurgery can benefit your practice.

ELSEVIER

Booth #: 117
Contact: Tony Norton
Address: 8457 Eagles Loop Cr.
Windermerge, FL 34786
E-mail: t.norton@elsevier.com
Website: www.elsevier.com
Phone: 407.909.1528
Fax: 407. 909.1543
Product Category: Publishing

Elsevier is an international publisher of medical, surgical textbooks, periodicals and electronic media.

FOTOFINDER SYSTEMS, INC.

Booth #: 110
Contact: Annette Mayer
Address: 9693 Gerwig Lane, Suite S
Columbia, MD 21046
E-mail: info@fotofinder-systems.com
Website: www.fotofinder-systems.com
Phone: 443.283.3868
Fax: 443.283.3869
Product Category: Imaging & Photographic Equipment

FotoFinder Systems, Inc. sells imaging systems for consistent before and after photos of facial and body contouring treatments. Computer-controlled camera settings, tethered image capturing and the Ghost Feature lead to outstanding before and after photos, every time by any user.

HCGTRUEDIET.COM

Booth #: 519
Contact: Robert True
Address: 5203 Heritage Ave.
Colleyville, TX 76034
E-mail: robert@hcgtruediet.com
Website: www.hcgtruediet.com
Phone: 817.602.2439
Fax: 817.858.0302
Product Category: Weight Loss

HK SURGICAL

Booth #: 230
Contact: Clare Bennett
Address: 1271 Puerta del Sol
San Clemente, CA 92673
E-mail: hkinfo@hksurgical.com
Website: www.hksurgical.com
Phone: 949.369.0101
Fax: 949.369.9797
Product Category: Garments, Surgical Instruments, Medical Supplies

HK Surgical is the recognized leader in the development of highly specialized products in the medical device industry. We are the original designers of the HK Klein Infiltration pump and Klein Aspiration pump. We carry a full line of disposable tubing, garments, filters and Super Absorbent Pads. HK Surgical is proudly the exclusive source of the patented Capistrano Cannulas, Midine Positioning Pillow, and the HK Super Absorbent Pads. HK Surgical – Complete Tumescent Solution.

IMPLANTECH ASSOCIATES, INC

Booth #: 516
Contact: Kristine Durand
Address: 6025 Nicolle St., Suite B
Ventura, CA 93003
E-mail: kdurand@implantech.com
Website: www.implantech.com
Phone: 800.733.0833
Fax: 805.339.9414
Product Category: Implants

Implantech is the recognized leader in manufacturing nearly 200 sizes and designs of innovative silicone facial implants, including the revolutionary Conform Facial Implants. The company also provides ePTFE products and custom options. Through their sister company, Allied Biomedical, quality body-contouring implants (gluteal, pectoralis and calf) are available. Visit Implantech at Booth 516 or www.implantech.com.

INCREDIBLE MARKETING

Booth #: 301
Contact: West Jones
Address: 16441 Scientific Way
Irvine, CA 92618
E-mail: im@incrediblemarketing.com
Website: www.incrediblemarketing.com
Phone: 800.949.0133
Fax: 866.321.0688
Product Category: Practice Management

Incredible Marketing, Inc. is a full-service Internet Marketing firm with emphasis on custom website development and Search Engine Optimization (SEO). Our award-winning custom work is specifically geared towards the Medical and Professional industry. We bring a unique one-on-one approach to all clients, with an emphasis on developing a long-term plan for success.

INNOGYN, INC

Booth #: 431
Contact: Lisa Thorson
Address: 15499 Arnold Dr., Suite A
Glen Ellen, CA 95442
E-mail: lthorson@innogyn.com
Website: www.innogyn.com
Phone: 866.871.3516
Fax: 707.935.8454
Product Category: Surgical Instruments, Lasers & Laser Supplies

InnoGyn, Inc. specializes in developing comprehensive turn-key business opportunities for leading-edge cosmetic surgery applications. With extensive experience in training programs, technology and branding, we provide know-how to physicians in the aesthetic industry.

INNOVATIVE MED, INC

Booth #: 506
Contact: Dale Ekstrom
Address: 4 Autry, Suite B
Irvine, CA 92618
E-mail: dale@imibeauty.com
Website: www.imibeauty.com
Phone: 949.458.1897
Fax: 949.458.7416
Product Category: Cosmetic & Skin Care, Garments & Clothing, Disposable Medical Supplies, Lasers & Laser Supplies

INSTITUTE FOR MEDICAL QUALITY

Booth #: 224
Contact: Victoria Samper
Address: 221 Main St., Suite 210
San Francisco, CA 94105
E-mail: vsamper@imq.org
Website: www.imq.org
Phone: 415.882.5173
Fax: 415.882.5149
Product Category: Association

The Institute for Medical Quality's Ambulatory Care Review Program offers accreditation surveys and consultations for outpatient settings (surgery centers, offices, and medical groups).

INVASIX

Booth #: 520
Contact: Yang Phan
Address: 30 East Beaver Creek, #115
Richmond Hill, ON L4B1J2
E-mail: yangp@invasix.com
Website: www.invasix.com
Phone: 905.707.6787
Fax: 905.707.7085
Product Category: Surgical Instruments

Invasix develops, manufactures and markets minimally invasive aesthetic surgical platforms based on proprietary RFAL (Radio Frequency Assisted Liposuction) technology. The BodyTite device is the industry's first RF assisted liposuction workstation designed to eliminate fat cells while significantly tightening the body. This revolutionary procedure provides fast, uniform heating in the safest manner to both physicians and patients.

IRIDEX

Booth #: 103
Contact: Janet Amistoso
Address: 1212 Terra Bella Ave.
Mountain View, CA 94043
E-mail: info@iridex.com
Website: www.iridex.com
Phone: 800.388.4747
Fax: 650.962.0486
Product Category: Lasers

JAC-CELL MEDIC

Booth #: 227
Contact: Maria & Mark Meltzer
Address: 1176A Main St.
Champlain, NY 12919
E-mail: mark@jaccell.com, maria@jaccell.com
Website: www.jacell.com
Phone: 800.720.0931
Fax: 514.631.1351
Product Category: Surgical Instruments, Disposable Medical Supplies

Jac-cell Medic is a leading distributor of instruments and accessories for cosmetic surgery. We provide value and savings on the highest quality of disposable and reusable products. Breast retractors, microsurgery instruments, precision dissection needles, cautery pens, saline transfer systems, aspiration and infiltration tubing and the lowest prices on silicone drains and reservoirs, including the new "ouchless" 2-in-1 round drain.

LASERING USA

Booth #: 435
Contact: Jason Botting
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San Ramon, CA 94583
E-mail: jbotting@laseringusa.com
Website: www.mixtoskinsesurfacing.com
Phone: 866.471.0469
Fax: 925.355.0777
Product Category: Lasers

LASERING USA distributes the SLIM E30 MiXto SX® Fractional CO2 laser for fractional resurfacing, traditional resurfacing, and tissue cutting. This true fractional methodology uses a patent-pending delivery algorithm alternating between 4 quadrants in continuous wave mode with millisecond pulse durations to deliver a precise and predetermined treatment with a 300um or 180um spot. The MiXto offers the most effective thermal relaxation time for tissue cooling and collagen remodeling ensuring patient comfort, satisfaction and results.

LIPOSUCTION.COM, INC

Booth #: 234
Contact: Dawn Neff
Address: 30280 Rancho Viejo Rd.
San Jaun Capistrano, CA 92675
E-mail: dawn@liposuction.com
Website: liposuction.com
Phone: 949.369.7555
Fax: 949.369.7556
Product Category: Practice Management, Internet Advertising

Liposuction.com is the #1 surgeon directory on Google, MSN, Bing, AOL and all other major search engines! Thousands of patients come to our site to find a surgeon in their area. Capture these real time leads and earn the best return on your investment. Sign up today and start scheduling liposuction patients now: from out website to your waiting room.

LIPPINCOTT WILLIAMS AND WILKINS

Booth #: 121
Contact: Michael Torpey
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St. Cloud, FL 34771
E-mail: mtorpey@lww.com
Website: www.lww.com
Phone: 407.625.6375
Fax: 407.892.2067
Product Category: Publishing

LUMENIS

Booth #: 423
Contact: Debbie Savoie
Address: 5302 Betsy Ross Dr.
Santa Clara, CA 95054
E-mail: dsavoie@lumenis.com
Website: www.aesthetic.lumenis.com
Phone: 408.764.3511
Fax: 408.764.3660
Product Category: Surgical Instruments

Lumenis is the leading developer, manufacturer and marketer of proprietary laser and intense pulsed light (IPL) systems. Lumenis aesthetic systems are renown worldwide for advanced applications including scar reduction, fractional resurfacing, photo-rejuvenation, hair removal, improvement of vascular and pigmented lesions, and wrinkle reduction. Leading products include DeepFX and ActiveFX with UltraPulse, AcuPulse, LightSheer Duet, LumenisOne and M22.

LUTRONIC, INC

Booth #: 429
Contact: Evelyn Pettit
Address: 51 Everett Dr., A-50
Princeton Junction, NJ 08550
E-mail: office@lutronicusa.com
Website: www.lutronic.com
Phone: 888.588.7644
Fax: 609.275.3800
Product Category: Lasers

A global leader in aesthetic and medical laser systems, Lutronic is focused on providing advanced technology at an exceptional value. Our proven product portfolio reflects the company's core competency of excellence in creating innovative, intuitive and versatile laser systems that deliver long-lasting results for clinicians and patients worldwide. Products include systems for fractional laser resurfacing, tattoo and pigmented lesion removal, non-ablative rejuvenation, laser surgery and facial contouring.

MARINA MEDICAL INSTRUMENTS, INC.

Booth #: 101

Contact: Alex Barron
Address: 955 Shotgun Rd.
Sunrise, FL 33326
E-mail: alexbarron@marinamedical.com
Website: www.marinamedical.com
Phone: 954.924.4418
Fax: 954.924.4419
Product Category: Surgical Instruments

Marina Medical Instruments provides surgeons with the best value and selection of surgical instruments and equipment. Whether you specialize or only do sporadic minor procedures, Marina Medical is your best source for quality, service and price. Please stop by our booth and see why Marina Medical is the best choice for your surgical instrument needs.

MASTER PHARM, LLC

Booth #: 315

Contact: Thomas Mastanduono, RPh
Address: 115-06 Liberty Ave.
Richmond Hill, NY 11419
E-mail: tmasta@masterpharm.com
Website: www.masterpharm.com
Phone: 718.52.5500
Fax: 718.529.2780
Product Category: Pharmaceuticals

MasterPharm is a state-of-the-art compounding facility. We provide superior customer service plus quality custom compounded prescription drugs at competitive pricing. MasterPharm has an international reputation as an authority in pain management and anti-aging therapies. Sterile products are compounded in ISO-4 Class-10 clean rooms. We invite you to call our healthcare professionals for assistance with placing an order or to answer any questions.

MD RESOURCE

Booth #: 222

Contact: Mel Kimsey
Address: 23392 Connecticut
Hayward, CA 94545
E-mail: mel@mdresource.com
Website: www.mdresource.com
Phone: 510.732.9950
Fax: 510.785.8182
Product Category: Clothing, Surgical Instruments, Disposable Medical Supplies

Manufacturer and distributor of lipoplasty and fat transfer equipment and supplies: aspirators, infiltrators, cannulae, micro-cannulae; supplies such as garments, canisters, tubing, filters, etc.; and the new Tumescent Measuring Device (TMD). We also manufacture the AquaVage fat harvesting products and equipment.

MEDESTHETICS MAGAZINE

Booth #: 125
Contact: Craig Levy
Address: 7720 N. Dobson Rd.
Scottsdale, AZ 85256
E-mail: clevy@medicis.com
Website: www.restlyaneUSA.com
Phone: 602.808-8800
Fax: 602.808.0822
Product Category: Publishing

MEDICAL PROTECTIVE

Booth #: 405
Contact: Nancy Stahulak
Address: 5814 Reed Rd.
Fort Wayne, IN 46835
E-mail: nancy.stahulak@medpro.com
Website: www.medpro.com
Phone: 1.800.4MEDPRO
Fax: 866.417.5068
Product Category: Other

Since 1899 Medical Protective has been the nation's leader in medical professional liability. As a Warren Buffett Berkshire Hathaway Company, Medical Protective offers healthcare providers four levels of unmatched protection – strength, defense, solutions, since 1899. For more information, visit www.medpro.com or call 800-4MEDPRO.

MEDICIS AESTHETICS, INC.

Booth #: 312
Contact: Craig Levy
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Scottsdale, AZ 85256
E-mail: customer_service@medicis.com
Website: www.medicis.com
Phone: 602.808.8800
Fax: 602.808.0822
Product Category: Pharmaceuticals

Medicis Aesthetics is dedicated to helping patients attain a healthy and youthful appearance and self-image, and to help you redefine beauty in your patients. It's at the heart of everything we do for you. And it's why we offer a comprehensive collection of products for your facial aesthetics practice.

MEDICO INTERNATIONAL/ COOL JAW

Booth #: 107

Contact: Kerra Field
Address: PO Box 3092
Palmer, PA 18043
E-mail: info@medicointernational.com
Website: www.medicointernational.com
Phone: 877.411.7009
Fax: 610.253.1476
Product Category: Garments & Clothing, Other Medical Supplies

Visit Medico International to hear about our Hands-Free Cold Therapy® line, Cool-Jaw. Medico is also proud to offer the latest in post-operative garments, Sculptures Compression Wear. We continue to advance our line of products while maintaining the quality you expect and the modest price you love!

MEDI-KHAN

Booth #: 122

Contact: Peter Jung
Address: 8721 Sunset Blvd., Suite P5
West Hollywood, CA 90069
E-mail: peter2275@gmail.com
Website: www.medi-khan.com and www.lipo-kit.com
Phone: 310.358.0594
Fax: 310.358.0642
Product Category: Surgical Instruments

Medi-Khan Inc is the leader of adipose-tissue engineering. Our major medical devices are Lipokit for all-in-one Closed System for Lipo-condensation autologous faf grafting, FDA approved, MaxStem for real-time, in-room isolation of Adipose-derived Stem cells, FDA listed and the others, Filler-Geller for 26-30 gauge needle autologous fat tissue processing and Fat Scaffolds. Lipokit and its 50 cc FPU (Fat Processing Unit) syringes are the most advanced, standardized, all-in-one machine for condensed and Enriched Autologous Fat Grafting. Our 50 ml FPU syringes are specially designed to efficiently separate and remove the impurities and free oils and to concentrate and harvest the stem cells (ASCs) and young, healthy fat cells.

MED SPA CORE TRAINING

Booth #: 113

Contact: Jose Reyes, MD
Address: 12730 IH 10W, Suite 306
San Antonio, TX 78230
E-mail: marketing.healthnet@hotmail.com
Website: healthnetlaserandskin.com
Phone: 210.694.5800
Fax: 210.877.0785
Product Category: Practice Management

Million-dollar med-spa secrets revealed! Learn the marketing and business strategies essential to your infinite success through this exclusive, 3-day program that provides every tool necessary to build your existing practice into a prestigious, cash-paying business.

MENTOR

Booth #: 201
Contact: Susan Martony-Taylor
Address: 201 Mentor Dr.
Santa Barbara, CA 93111
E-mail: smartony@mentorcorp.com
Website: www.mentorcorp.com
Phone 800.525.0245
Fax: 805.967.3013
Product Category: Cosmetics, Garments, Implants, Surgical Instruments, Pharmaceuticals

Mentor is a world leader in breast implants manufacturing, research and testing and continues to provide a broad selection of products and services to enhance your practice. Our MemoryGel™ and saline implants are available in a wide array of styles, sizes, and textures, our Byron line of body contouring products is one of the most comprehensive in the industry, and our practice management division, Mentor Solutions, has helped build successful, better managed and more profitable cosmetic practices for over a decade. Mentor continues to expand the range of science-based, aesthetic products by offering NIA 24TM, a niacin-based skin therapy which will complement our Prevelle Silk dermal filler and botulinum toxin products.

MERCK & CO, INC

Booth #: 314
Contact: Gal Griffith
Address: 351 N. Somneytown Pike
North Wales, PA 19454
E-mail: info@merck.com
Website: www.merck.com
Phone: 267.305.5000
Fax: 267.305.1266
Product Category: Pharmaceutical

MERGE MAGAZINE

Booth #: 433
Contact: Cindy McKown
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Carol Stream, IL 60188
E-mail: cmckown@allured.com
Website: www.mergeonline.com
Phone: 630.344.6064
Fax: 630.597.0118
Product Category: Publishing

MERZ PHARMACEUTICALS

Booth #: 427, 526
Contact: Lydia Cornacchione
Address: 4215 Tudor Lane
Greensboro, NC 27410
E-mail: lcornacchione@merzusa.com
Website: www.merzusa.com
Phone: 336.217.2424
Fax: 336.856.0107
Product Category: Pharmaceuticals

Merz Pharmaceuticals, LLC, the U.S. subsidiary of the Merz Group of Companies was established in 1995 and develops and commercializes products for Aesthetic Medicine, Dermatology, Neurology, and Podiatry. Merz's (KGaA) 101-year heritage is known worldwide for its development of original compounds for medical professionals and consumers in 90 countries.

MICROAIRE SURGICAL INSTRUMENTS

Booth #: 220
Contact: Jane Fairbrother
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E-mail: jane.fairbrother@microaire.com
Website: www.microaire.com
Phone: 434.975.8000
Fax: 434.975.8014
Product Category: Surgical Instruments

MicroAire Plastic Surgery Products is an innovative company focused on liposuction and other key plastic surgery products. MicroAire is the world leader in Power Assisted Lipoplasty (PAL®) technology and provides other products such as Endoscopic Carpal Tunnel Release System, EpiCut™ (Epithelium tissue removal instrument), and ReleaseWire™ (Subcutaneous dissection instrument for removal of wrinkles).

MICROSURGERY INSTRUMENTS, INC.

Booth #: 407
Contact: Nancy Kang
Address: PO Box 1378
Bellaire, TX 77402
E-mail: microusa@microsurgeryusa.com
Website: www.microsurgeryusa.com
Phone: 713.664.4707
Fax: 713.664.8873
Product Category: Surgical Instruments, Imaging, Other Equipment & Supplies

Microsurgery Instruments is one of the leading suppliers of surgical instruments and loupes. Our new instruments include: titanium scissors, needle holders, and forceps. Our Super-Cut scissors are the sharpest in the market, and our newly designed surgical loupes offer up to 130mm field of view and up to 11x magnification.

MILTEX, INC.
PADGETT INSTRUMENTS BY MILTEX

Booth #: 420
Contact: Marcy Osborn
Address: 589 Davies Dr.
York, PA 17402
E-mail: customerservice@miltex.com
Website: www.miltex.com
Phone: 866.854.8300
Fax: 866.854.8400
Product Category: Surgical Instruments

Miltex and Padgett Instruments is a new partnership between two highly respected names in Plastic Surgery and General instrumentation. These classic brands provide a combination of choice and premium German craftsmanship unmatched by any other instrument company. Visit the Miltex and Padgett booth to see two great brands from great company.

MJD PATIENT COMMUNICATIONS

Booth #: 204, 206
Contact: Kristy
Address: 4915 St. Elmo Ave., Suite 306
Bethesda, MD 20814
E-mail: kristy@mjdpc.com
Website: mjdpc.com
Phone: 301.657.8010 or 800.326.4869
Fax: 301.657.8023
Product Category: Patient Education

Say goodbye to your webmaster! MJD Websites feature society-endorsed, Google-friendly, Optimized Content, Before and After Photos, a Search Engine Optimizer (SEO) and Content Management System (CMS) that let you edit your website anywhere, anytime. Check out our Procedure Brochures, Slide Presentations, Messages-On-Hold and our AACS member pricing.

NEOSTRATA COMPANY, INC

Booth #: 515
Contact: Monica Martin
Address: 307 College Road East
Princeton, NJ 08540
E-mail: custsvc@neostrata.com
Website: www.neostrata.com
Phone: 609.986.2939
Fax: 609.986.1839
Product Category: Cosmetics & Skincare

NeoStrata has a passion for the Science of Great Skin, and for the innovative research and meticulous development of products to address a range of aesthetic and therapeutic needs. Advanced technology, including patented Bionic acids, delivers proven benefits in skin rejuvenation and treatment. Brands: NeoStrata®, Psorent®, Exuviance®, CoverBlend®.

NEXTECH SYSTEMS, INC.

Booth #: 316
Contact: Vanessa Kmet
Address: 5550 W Executive Ave., Suite 350
Tampa, FL 33609
E-mail: teammktg@nextech.com
Website: www.nextech.com
Phone: 813.425.9200
Fax: 813.425.9292
Product Category: Practice Management, Computer Hard/Software

O'DELL JARVIS MANDELL, LLC

Booth #: 115
Contact: David Mandell, JD, MBA
Address: 401 Elas Olas Blvd., #1400
Fort Lauderdale, FL 33301
E-mail: mandell@ojmgroup.com
Website: www.ojmgroup.com
Phone: 800.554.7233
Fax: 866.913.4911
Product Category: Practice Management

O'Dell Jarvis Mandell, a financial consulting firm, has 1,000 physician clients nationwide. With attorneys, CPAs, insurance, benefits and investment experts in-house, we provide true comprehensive planning. Our ideal client is a physician who wants to keep more of what he/she earns and expose less to taxes, lawsuits and poor performing investments.

PALOMAR MEDICAL TECHNOLOGIES

Booth #: 226
Contact: Bruce Philbrick
Address: 82 Cambridge St.
Burlington, MA 01803
E-mail: info@palomarmedical.com
Website: www.palomarmedical.com
Phone: 800.PALOMAR (800.725.6627)
Phone: 781.993.2300
Fax: 781.993.2330
Product Category: Lasers

Palomar Medical Technologies, Inc. develops the most advanced laser and pulsed-light systems for aesthetic applications including body sculpting, permanent hair reduction, fractional skin resurfacing, and skin rejuvenation. Palomar's StarLux®500 and SlimLipo™ systems empower doctors to offer remarkable results with exceptional versatility, ease of use, and comfort. Discover "From Light Comes Beauty" at palomarmedical.com.

PCA SKIN

Booth #: 212
Contact: Stephanie Nervegna
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Greensboro, NC 27410
E-mail: info@pcaskin.com
Website: www.pcaskin.com
Phone: 480.946.7221
Fax: 480.946.5690
Product Category: Pharmaceuticals

In 1990 PCA SKIN developed the first line of clinically researched products and blended chemical peels to promote skin health, marketed directly to physicians. Dermatologist Jennifer Linder, MD provides the industry with innovative, proprietary formulations to improve the skin. The company is also recognized globally as an invaluable educational resource for physicians and clinicians alike.

PHOTOMEDEX

Booth #: 124
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Montgomeryville, PA 18936
E-mail: arock@photomedex.com
Website: www.photomedex.com
Phone: 215.619.3600
Fax: 215.619.3208
Product Category: Cosmetics & Skin Care, Lasers & Laser Supplies

PLASTIC SURGERY STUDIOS

Booth #: 413
Contact: Leisa Weyant
Address: 8667 Haven Ave., Suite 200
Rancho Cucamonga, CA 91730
E-mail: leisa@plasticsurgery.com
Website: www.plasticsurgery.com
Phone: 909.785.8331
Fax: 909.758.8386
Product Category: Patient Education

Plastic Surgery Studios provides total Internet marketing solutions for plastic surgeons, cosmetic surgeons, dermatologists, and cosmetic dentists everywhere. We give medical professionals the opportunity to promote their practices regionally, nationally and internationally – specializing in Web Design, Search Engine Optimization, Directories, Blogs and Video Marketing.

PRACTICEDOCK POWERED BY LOCATEADOC.COM (MOJO INTERACTIVE)

Booth #: 214, 216
Contact: Dana DeZoort
Address: 1060 Woodcock Rd.
Orlando, FL 32803
E-mail: info@practicedock.com
Website: www.practicedock.com
Phone: 407.206.0700
Fax: 407.206.3376
Product Category: Patient Education, Practice Management

You're not just running a practice, you're running a business. Let PracticeDock help. This virtual marketing-in-a-box tool provides cost-effective online marketing solutions with real-time visibility and results to transform quality prospects into business. Identify, connect and communicate with prospective patients to optimize your marketing efforts. www.practicedock.com or 877.665.6798.

PROJECTED GROWTH CONSULTING GROUP

Booth #: 303
Contact: West Jones
Address: 524 W. Sixth Ave.
Spokane, WA 99204
E-mail: kellymedspa@gmail.com
Website: www.incrediblemarketing.com
Phone:509.458.SKIN (9118)
Fax: 509.444.2877
Product Category: Practice Management

Projected Growth Consulting Group is an aesthetic and business consulting company that specializes in the Medical Spa and Aesthetic Practice. We specialize in: CME Training for Laser-Assisted Liposuction, Advanced Injectable Techniques and Liquid Lifts, Staffing, Operations, Sales and Consultative Training, Marketing, Financial Analysis and Consulting, Staff Compensation and Incentive Modeling.

PSP: PLASTIC SURGERY PRACTICE

Booth #: 504
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Website: www.plasticsurgerypractice.com
Phone: 913.894.6923 x652
Fax: 913.894.6932
Product Category: Publishing

PSP: Plastic Surgery Practice targets 12,000 plastic and aesthetic surgery professionals with the latest information on clinical innovations, practice-management trends, news analysis, and emerging products and technologies to help them manage successful practices.

QUALITY ASPIRATORS & Q-OPTICS

Booth #: 116
Contact: Kathryn Hairston
Address: PO Box 382120
Duncanville, TX 75138
E-mail: support@q-optics.com
Website: www.q-optics.com
Phone: 800.858.2121
Fax: 972.298.6592
Product Category: Medical Equipment & Supplies

Q-Optics manufactures the lightest custom and flip style loupes. Portable LED headlights and fiber-optic headlights are also available. Visit us on the web at www.q-optics.com or toll free at 800.858.2121.

QUALITY MEDICAL PUBLISHING

Booth #: 114
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St. Louis, MO 63146
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Website: www.qmp.com
Phone: 314.878.7808
Fax: 314.878.9937
Product Category: Publishing

ROBBINS INSTRUMENTS

Booth #: 511
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Chatham, NJ 07928
E-mail: info@robbinsinstruments.com
Website: www.robbinsinstruments.com
Phone: 800.206.8649
Fax: 973.635.8732
Product Category: Surgical Instruments, Disposable Medical Supplies, Other Medical Supplies

Robbins Instruments invites you to stop by our booth, or contact us about our complete line of Sapphire Knives for Hair Transplant Surgery, Ceramic Coated Supercut Scissors, or our Micromotor Systems for Dermabrasion, Microdermabrasion and Micropigmentation procedures. Also, add additional hand pieces at a significant meeting discount.

SANDSTONE MEDICAL TECHNOLOGIES

Booth #: 320
Contact: Mike Portera
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Homewood, AL 35209
E-mail: sandstonemike@bellsouth.net
Website: www.sandstonetechnologies.com
Phone: 205.290.8251
Fax: 205.290.4269
Product Category: Lasers

Sandstone Medical provides aesthetic lasers at an affordable price. Our product line includes: The Matrix Co2 for fractional skin resurfacing, The Whisper-NG for "Lunch time" LaserPeels and The UltraLight-Q for the removal of tattoos. We also provide pre-owned lasers from Candela, Lumenis and Iridex for the removal of unwanted body hair and vascular and pigmented lesions.

SBMI

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Website: www.myzerona.com
Phone: 805.806.8086
Product Category: Cosmetics, Lasers

SCITON

Booth #: 417
Contact: Carol Reynolds
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Palo Alto, CA 94303
E-mail: information@sciton.com
Website: www.sciton.com
Phone: 650.493.9155
Fax: 650.493.9146
Product Category: Lasers

Sciton provides best-in-class laser and light source solutions for medical professionals who want superior durability, performance, and value. We offer high quality, expandable platforms with modules for fractional skin resurfacing, superficial and deep skin peeling, laser-assisted lipolysis, wrinkle reduction, hair removal, treatment of vascular and pigmented lesions, phototherapy, scar reduction, and treatment of varicose veins and acne.

SERATONIN PLUS, INC

Booth #: 512

Contact: Jessica Mueller
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Burke, VA 22015
E-mail: jmueller@spdiet.com
Website: www.spdiet.com
Phone: 703.866.4144
Fax: 703.866.1271
Product Category: Cosmetics & Skin Care, Practice Mangement

The Serotonin-Plus Weight Loss Program™ allows physicians to add a successful, safe and effective weight loss program into an existing practice. Practitioners immediately run a profitable business by utilizing existing staff, patient base, and current overhead, as patients become healthier and happier.

SHIPPERT MEDICAL

Booth #: 317

Contact: Angie Mediger
Address: 6248 S. Troy Circle, Suite A
Centennial, CO 80111
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Website: www.shippertmedical.com
Phone: 800.888.8663
Fax: 303.754.0318
Product Category: Clothing, Implants, Surgical Instruments, Medical Equipment

Shippert Medical has been supplying cosmetic surgeons with innovative products for over 30 years, and is the source for all rhinoplasty, liposuction and fat transfer products. Products consist of the Denver Splint, the Rhino Rocket, Aquaplast, the Tissu-Trans for autologous fat transfer, cannulas, electrocautery, garments and aquaplast.

SMILE REMINDER

Booth #: 409

Contact: Bruce McKay
Address: 210 N 1200 E, Suite 150
Lehi, UT 84043
E-mail: info@smilereminder.com
Website: www.smilereminder.com
Phone: 866.605.6867
Fax: 801.772.2034
Product Category: Practice Management, Computer Hard/Software

Smile Reminder is a practice-to-patient communication service designed to maintain and retain existing patients while identifying and acquiring new patients. Utilizing the latest in messaging technologies, Smile Reminder helps you to increase productivity and grow your practice, while you focus on your patients!

SOLTA MEDICAL

Booth #: 327
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Hayward, CA 94545
E-mail: mhollenbach@solta.com
Website: www.solta.com
Phone: 510.782.2286
Fax: 510.782.2287
Product Category: Lasers

SoIta Medical is a global leader in the medical aesthetics market providing innovative, safe and effective anti-aging solutions for patients that enhance and expand the practice of medical aesthetics for physicians. The company offers products to address aging skin under the industry's two premier brands: Thermage® and Fraxel®. Call 877.782.2286 or go to www.solta.com.

SOUND SURGICAL TECHNOLOGIES LLC

Booth #: 326
Contact: Catherine Roth
Address: 357 South McCaslin Blvd., Suite 100
Louisville, CO 80027
E-mail: info@vaser.com
Website: www.vaser.com
Phone: 888.471.4777
Fax: 720.294.2948
Product Category: Surgical Instruments

VASER® Lipo, by Sound Surgical Technologies, is a minimally invasive body contouring procedure that can be performed in-office and provides practices additional income while expanding their continuum of care. The VASER Lipo System utilizes ultrasonic energy to emulsify targeted fat while preserving tissue critical to fast recovery and smooth results.

STIEFEL LABORATORIES

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Coral Gables, FL 33134
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Website: www.stiefel.com
Phone: 678.889.4034
Fax: 770.945.5424
Product Category: Cosmetics & Skincare

STRADIS HEALTHCARE

Booth #: 534
Contact: Bret Buhler
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Lawrenceville, GA 30045
E-mail: bretbuhler@att.net
Website: www.stradishealthcare.com
Phone: 770.962.2425
Fax: 770.962.2391
Product Category: Disposable Medical Supplies

Stradis Healthcare is the largest manufacturer of custom-made, single-use packs. Stradis packs are fully customized to meet your exact surgical requirements. Our packs reduce costs and set-up time and streamline your inventory. Contact us today at 800.886.7257 to inquire about our cost-saving strategies. "Customized doesn't come from a catalog."

SUNEVA MEDICAL

Booth #: 232
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San Diego, CA 92121
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Fax: 858.550.9997
Product Category: Pharmaceuticals

SURGIFORM TECHNOLOGY, LTD

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Columbia, SC 29229
E-mail: surgiform@bellsouth.net
Website: www.surgiform.com
Phone: 803.462.1712
Fax: 803.462.1743
Product Category: Implants

Surgiform is a bio-medical company specializing in developing, manufacturing and distributing aesthetic surgical products. Products: ePTFE facial implant material (suture, round and oval strand, sheet, carvable block and 3-D ePTFE implants), Silicone Implants (nasals, chins and malars), Saf-T-Vac® (Removes harmful smoke, odors and fluids during electro surgery procedures).

SURGITEL/GENERAL SCIENTIFIC CORP

Booth #: 416

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Address: 77 Enterprise Dr
Ann Arbor, MI 48103
Email: info@surgitel.com
Website: www.surgitel.com
Phone: 734.996.9200
Fax: 734.662.0520
Product Category: Surgical Instruments, Imaging, Lasers

SurgiTel Systems is dedicated to offering the best in ergonomics, vision and comfort. Coupling SurgiTel Systems' High Definition Optics with Oakley Frames, we offer the very best in magnification systems. SurgiCam, our new loupe-mounted camera system, is digital and lightweight allowing the viewers to see images at the user's perspective.

THE AESTHETIC GUIDE

Booth #: 111

Contact: Silvia Kranciss
Address: 120 Vantis, Suite 470
Aliso Viejo, CA 92626
E-mail: Silvia@miinews.com
Website: www.miinews.com
Phone: 949.830.5409
Fax: 949.830.8944
Product Category: Publishing

THE Aesthetic Guide, which has a readership of 20,000 medical aesthetic practices, is published by Medical Insight, Inc. We also publish THE European Aesthetic Guide. Free subscriptions are available to qualified medical aesthetic practices. Medical Insight, Inc. also conducts market research and publishes market studies. Visit www.miinews.com for a complete list of services.

THE JOINT COMMISSION

Booth #: 109

Contact: Darrell Anderson
Address: One Renaissance Blvd.
Oakbrook Terrace, IL 60181
E-mail: danderson@jointcommission.org
Website: www.jointcommission.org/OBS
Phone: 630.792.5292
Fax: 630.792.4292
Product Category: Accreditation

Joint Commission accreditation is a visible demonstration to your patients, staff, payers and community that you have taken extra steps towards providing the safest, highest quality care. For more information on achieving The Joint Commission's "Gold Seal of Approval™" for your practice, visit booth #109 or call 630.792.5292.

THE REVIEW BOOK

Booth #: 509
Contact: Herb Singh
Address: 7000 Covered Bridge Dr.
Austin, TX 78736
E-mail: herb.singh@trb-mail.com
Website: www.thereviewbook.com
Phone: 888.602.1977
Fax: 512.607.6254
Product Category: Computer Hardware & Software

TULIP MEDICAL PRODUCTS

Booth #: 401
Contact: Marcille Pickington
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San Diego, CA 92167
E-mail: tulipco@aol.com
Website: www.tulipmedical.com
Phone: 619.255.3141
Fax: 619.255.4138
Product Category: Clothing, Surgical Instruments, Disposable Medical Supplies

Tulip – Simply the Best. World renowned innovators of the Tulip Syringe System present the Leaders' Choice in macro and micro body sculpting instruments: The patented SuperLuerLok Micro Injectors, patent-pending CellFriendly technology for superior cell survivability and the Tulip facial and body sculpting systems. The Leaders' Choice. Simply the Best. Visit our booth and find out who's using Tulip.

UNDERSTAND.COM

Booth #: 120
Contact: Jennette Ackley
Address: 100 Washington, Suite 100
Reno, NV 89503
E-mail: jennette@understand.com
Website: www.understand.com
Phone: 775.851.3420
Fax: 775.851.7860
Product Category: Patient Education

Understand.com offers plastic and cosmetic surgeons world-class 3D Patient Education and Marketing Animations that are integrated into your website, saving you and your staff valuable time, while better educating your patients. The 3D animation library, containing over 50 animated procedures, treatments and conditions, is customized exclusively for your practice and integrated into your existing website in minutes. Customization includes your practice logo, colors, Before & After Photos, branded print brochure and links to your CV and Contact Us pages.

UNITED IMAGING

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Website: www.unitedimagingusa.com
Phone: 800.336.5484
Fax: 704.908.1393
Product Category: Cosmetics & Skin Care, Lasers & Laser Supplies

WELLS JOHNSON

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Contact: Grace Alas
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Tucson, AZ 85756
E-mail: grace@wellsgrp.com
Website: www.wellsgrp.com
Phone: 800.528.1597
Fax: 520.885.1189
Product Category: Clothing, Surgical Instruments, Disposable Medical Supplies, Other Supplies

Wells Johnson Company introduces EVOLUTION™: changing the way the physician infiltrates, aspirates, harvests and re-injects, effectively shifting the paradigm of how cosmetic surgery is performed. Using the EVOLUTION™, a single, anaerobic, closed system, the surgeon utilizes precise controls of flow rates, vacuum levels and pressure, leading to a fully integrated, seamless and continuous procedure. EVOLUTION™ will be the new face of cosmetic surgery and promises to provide the same product quality you have come to enjoy from Wells Johnson since 1983.

YODLE

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New York NY 10010
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Website: www.yodle.com
Phone: 877.276.5104
Fax: 212.868.1989
Product Category: Marketing

Yodle provides local businesses with a simple and affordable way to get new customers and phone calls using online advertising. Yodle is transforming local online advertising by connecting local business owners with consumers in a simple, measurable and relevant way. Yodle has developed an integrated approach to signing up and serving local businesses that are transitioning their marketing budgets online. Yodle is headquartered in New York, NY with a presence in 25 major cities across the United States and has hundreds of employees helping thousands of customers.

EXHIBITOR LISTING

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

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S – Cynosure; S – Syneron

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AB, C, SP & H – Medicis Pharmaceuticals, Inc.

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No relevant financial relationships exist.

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C, T & E – CoolTouch

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C – Lexington; R – A to Z Surgical

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O – OJM Group

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R – KMI

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C, E & H – Invasix

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G – Cynosure

O

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O – The Professional Image, Inc

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P

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MARCO A. PELOSI III, MD
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S

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C & E Cynosure; C & E – Palomar

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E & S – Sound Surgical Technologies

JEFFRY B. SCHAFER, MD
C, E & G – Palomar

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E – Strategic Edge Partners

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O, E & S – Shippert Medical Technologies

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AB, C, SP, H – Medicis Pharmaceuticals, Inc.

T

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REBECCA TUNG, MD
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W

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ROBERT A. WEISS. MD
C, I, S & G – Cynosure: I, S, G & H – Palomar

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