Experts Forum

Newsletter

TURKEY, OCTOBER 26 - 28, 2007

The 3rd Aesthetics Experts Forum gathered 20 plastic surgeons from 9 different countries.

The two guest speakers for this Experts Forum in Istanbul, Turkey were Dr Herve Raspaldo and Dr Rogerio Neves.

Dr Herve Raspaldo ,a facial plastic surgeon from Cannes,presented the latest trends in non-surgical facial treatments and conducted a live injection workshop.

Dr Rogerio Neves, a plastic surgeon from Brazil but based in the USA, gave a presentation and chaired an open discussion on patient cases for breast augmentation.

In this newsletter you will find a summary of the main topics discussed, included the interviews done to these two speakers.

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Non Surgical Anti-Ageing Facial Treatment

"Restore a natural look", combination treatment BOTOX & Juvéderm.

by Dr Herve Raspaldo, Cannes, France

Simply "Natural look - how to restore it"

Botox + Juvéderm + Voluma

Slide 1: Allergan Facial Aesthetic portfolio

Case 1:

(central picture) Lady 67 years old with a sad face, after a Facelift + Upper & Lower Blepharoplasty in the 90's. The midface is hollow, with malar hypotrophy, strong dynamic forehead lines and eyebrows asymmetry.

(left picture) Same beautiful lady at 18 years old when she was a model in Paris in the 60's.

(right) Result after 1 year and:

– 2 Botox sessions in upper face + chin (50 U/session every 6 month)

– Juvederm ULTRA 2 or 3 in Tear trough + Nasolabial folds + upper Lip (3x 0.8cc)

– Voluma in central & lateral midface (malar & maxilla): 2cc / side = 4cc

VOLUMA sub-orbicularis & submalar fat pad deep injections

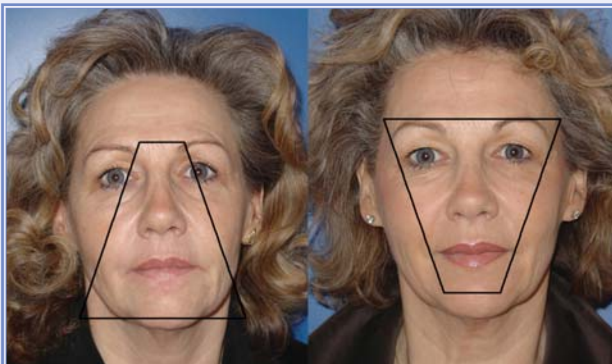
Slide 2: Three dimensional projection of the anatomical components (oblique view)

(right picture)

- Deep plane Facelift flap including: skin & subcutaneous fat, Orbicularis Oculi muscle, Malar fat pad, Platysma.
- Drawing: the yellow heart represents the volume injection; the green arrow shows direction and depth of the volumizing injection on top of the Zygomaticus muscles

(left picture)

Temporal artery, facial nerve, malar fat pad, zygomaticus major muscle, Depressor Angulis Ori muscle (DAO)



Botox + Juvéderm + Voluma

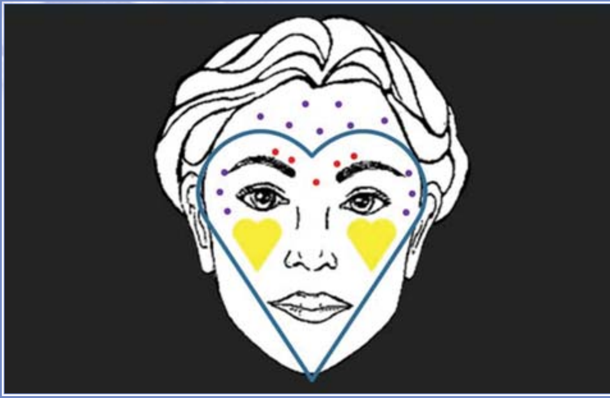
Slide 3: Reverse triangle of Beauty (frontal view – Lady 57 years old)

– Botox in Upper face (Orbicularis oculi muscles + Glabella= 45 U, DAO & Platysma= 16 U): total 61 U

– Juvederm ULTRA 2 or 3 in Nasolabial fols: (0.4cc/side) + Upper Lip 0.4cc

– Voluma in midface atrophy: 1cc/side

Triangle of Beauty – Heart of Face



Slide 4:

Typical Botox (purple dots = 2 U; red dots = 4U) and Juvéderm VOLUMA (yellow) Injection Mid-Facial Sites.

That is the way to shape an attractive younger visage and to create that Triangle of Beauty - Heart of Face.

Slide 5: 46 years old lady

before:

Hollow eyes, Malar descent, Nasolabial folds, Marionette lines, dynamic wrinkles

3 month after:

Botox 40U / Upperface + 30U Lowerface

Juvéderm Ultra 2 – 0,55cc / side (NLF+Marionettes)

Voluma – 2cc / side (sub-Palpebral + Malar lateral)

The face is more attractive and natural thanks to the Allergan portfolio:

– Maximum comfort during the injection thanks to Juvéderm Ultra (including Lidocaïne).

– Natural look and safety with Botox/Vistabel

– Volume enhancement like in a younger face thanks to Voluma.

Patient satisfaction is very high.

INTERVIEW

Dr Hervé Raspaldo, Facial Plastic Surgeon, Cannes

1. As a plastic surgeon, why did you decide to do non surgical facial procedures, and not just invasive procedures in your practice?

I moved from 10% in 1992 **up to 80% of non surgical facial rejuvenation procedures in 2007**, (and still increasing my surgical cases). So I decided to change private practice constantly in 15 years for many reasons:

1 – *the patient demand & satisfaction:* in the new 3rd millennium people want to be healthy, active, to look young, beautiful…with less aggressive therapy and no downtime.

2 – *I love to work in my own private office because:*

- it is a gain of time and less cost. In surgery we always depend of other structures (clinic, material..) and persons (anaesthesiologist, nurses, employees that we do not control at all).
- to welcome patients in an attractive place that I created myself: the cosmetic patients want to come and spend a good time with me and my staff; and to go back home happy and more beautiful.

3 – *I love to create (or reshape) a 3D visage:*
Those new combination therapies are so complementary that the results (with education, learning curve…and an artistic taste) are as impressive as the surgical ones. I love both philosophical and technological aspects of the volumizing injections. It is like a surgical replacement… but easiest, in an office!

4 – *The immediate benefit for me:*
costs reduced, augmentation of patient's survey, higher conversion rate of patient into other treatments, augmentation of patient population (indirectly augmentation of surgical patients).

5 – *Excellent products in the Allergan facial portfolio:*
safety, versatility, knowledge, patients trust.

2. Based on your experience, what do you foresee as the future trend in non-invasive procedures?

– more **volumizing and Facial-3D**,
– more global combined treatments (eg.Botox®+Juvéderm) rather than wrinkles-lines injections or localized-limited injections,
– **Maximum patient comfort:** using the exclusive Allergan **Juvederm ULTRA + Lidocaine (no pain treatment)**
– Long duration non permanent fillers: 2-3 years duration
The consequence of those preventive therapies would be to start younger (<30yo) the beauty programs (like my Facial-3D).

3. What do you think patients will be looking for? A facial look , or a natural look?

Patients are 99% looking for a natural look with an attractive, elegant visage…not a smooth, frozen, puffy strange face!

I am working on the "Fractal theory" who demonstrates how the cortex is informed directly and relaxed by the harmonious curves of the Nature (like a landscape, or a sunset, or clouds in the sky…)…and by a smile or a natural beautiful face *(see bibliography below).*

4. What combination therapies do you use most in your practice in order to get that " reverse triangle" look lost due to ageing?

I published recently an article in the Journal of Cosmetic laser Therapy in august 2007 and a scientific poster in February 2007 (see bibliography below) concerning the **concept of Facial-3D**:
– Botox in upper & lower facial depressors, in a subtle equilibrium, to pull all facial soft tissues,
– Midface volumizing with Juvéderm/Surgiderm 30 or Voluma to put the midface in tension,
– Juvéderm Ultra / Surgiderm 24XP (or 30XP) for wrinkles refinements and contour.
The best is to use Botox 2 weeks before (or 4 weeks later). Then J30 or Voluma . Then JU or S24/30XP for refinement.

5. What combination therapy can you use to restore a patients look when there is a loss of tissue?

1) Restore where it is lost:
fillers in Lips, Nasolabial folds, wrinkles, chin, ovale contour
2) Augment the paramount projections: to reduce the folding, the tissue plication due to gravity.
The best is:
– a deep pillow as support of Voluma (or J30): eg.Midface atrophy
– at day 30: subtle touch up (or contouring) with JU / S24XP.

6. What would your advice be to young plastic surgeons who might consider including non-invasive procedures in their practice?

The young plastic surgeons and young doctors in general must learn as soon as possible those simple procedures because:
– more you're young, more you're flexible, more you're mentally open, easiest it is to learn new things!
– to start a private practice is easier with injections rather than facelift !!!
– a personal advice: "never miss the wagon, otherwise it takes ages to fit in again…"
I am so surprised to see how few surgeons in Europe are interested by non surgical procedures (compared to dermatologists or GP's).

7. What is your opinion of our Experts Forum?

The Experts Forum meetings are so helpful for everybody:
1) *for the participants:*
– knowing better each other, personally: it is the incomparable "human contact"(eg. useful for difficult patients, adverse events..)
– sharing knowledge from different culture, medical schools, c ountries, specialties…
– learning new things from experts.
2) *for the patients:*
they will indirectly benefit from the new expertise of the participants.
3) *for the Experts:*
– to make a high effort of teaching in front of foreign leaders,
– to share ideas with distinguished colleagues,
– to ask more directly new suggestions and partnership to Allergan.
4) *for the Allergan company:*
– to learn quickly new trend, new techniques; to feel better the evolution of the market.
In conclusion it is an exclusive educational program.
And let me say: "Bravo" for the organisation, friendship…and that cleaver newsletter!

1. *Fagien S, Raspaldo H. Facial rejuvenation with botulinum neurotoxin: an anatomical and experiential perspective. J Cosmet Laser Ther 2007;9(suppl 1):23-31*
2. *Raspaldo H. Facial design, architecture and volume - the new 3D sculpture using botulinum toxin and deep injectable fillers: facial rejuvenation using Btx expertise combined with injectable fillers in upper, mid and lower face.[poster] Allergan Academy, Poster session, London April 13, 2007*
3. *Raspaldo H, Bettens RMA, Giordano P. Midface enhancement. In: Vuyk HD, Lohuis PJ, eds. Facial Plastic and Reconstructive Surgery. Hodder Arnold Publication, New York: Oxford University Press, 2006:101-122*
4. *Raspaldo H. Volumising effect of a new hyaluronic acid sub-dermal facial filler: A retrospective analysis based on 102 cases (submitted to J Cosmet Laser Ther 2008)*

www.herveraspaldo.com

Breast Implants

The paradigm in breast surgery is measurement & planning.

by Dr Rogerio Neves, Brazil, based in USA

PRE-OPERATIVE PLANNING STEP 1: ASSESSING THE BREAST-CHEST

- **Assess symmetry**
- Visual assessment
- Suprasternal notch to nipple
- **Breast base width**
- Cornerstone
- Measure with calipers/ruler
- **Nipple to IMF**
- **Evaluation of soft tissue coverage**
- Visual assessment
- Elasticity
- Parenchyma

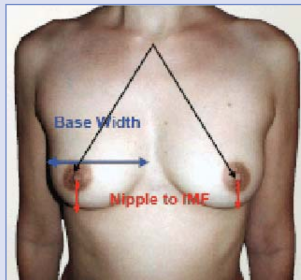


Photo courtesy of Rogerio Neves, MD
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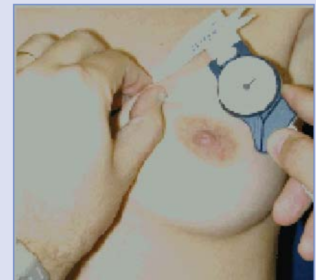
SOFT-TISSUE EVALUATION HELPS DETERMINE POCKET LOCATION

- Important to optimize soft tissues coverage
- Subglandular placement is more favourable with an upper pinch › 2cm
- Evaluate other parameters to determine optimal soft tissue coverage

Superior Pole Pinch Test



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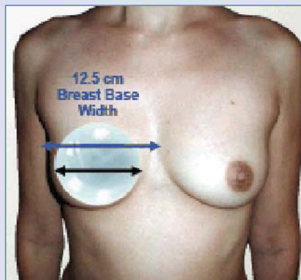
PRE-OPERATIVE PLANNING STEP 2: DECISIONS – IMPLANT SELECTION

- Basic principle – Implant width generally should not exceed breast base width
- Implant dimensions (volume) determined by:
  - – Breast base width
  - – Skin envelope
  - – Parenchyma
- Type of implant determines distribution of fill within breast



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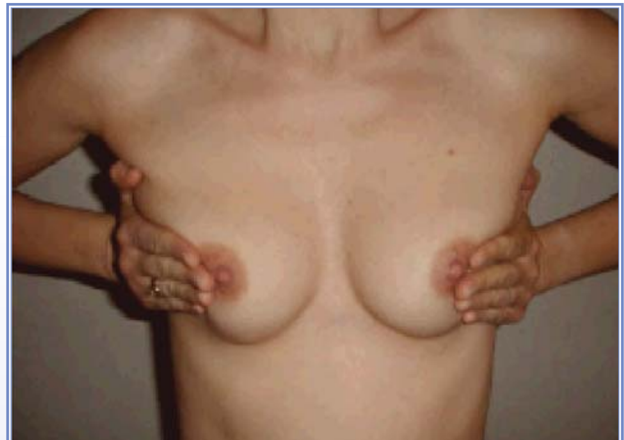
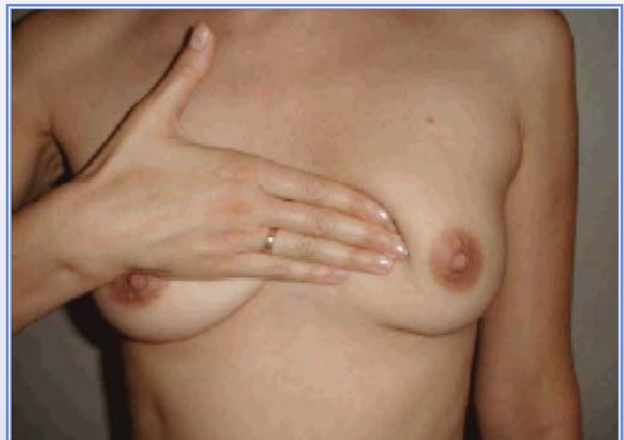


Above are the 2 main steps related to pre-operative planning in primary breast augmentation. It is crucial for the surgeon to assess the symmetry between both breasts, as well as to select an implant with a base width no greater than the breast. It is necessary to evaluate the breast parenchyma thickness (BPT), defining if it is small, moderate or large.

To measure the envelope tightness, just grasp the skin of the areola and pull anterior to the maximum stretch the skin tolerates. Mark the anterior most extent of stretch with the index fingernail. Then release the skin and with the help of the calliper you can measure the range of skin stretch from the skin surface to the index fingernail.

An alternative to determine the desired breast width (DBW) would be to displace the breasts medially to obtain the desired intermammary distance; then repeat the same procedure by displacing the breast laterally to obtain the desired lateral border.



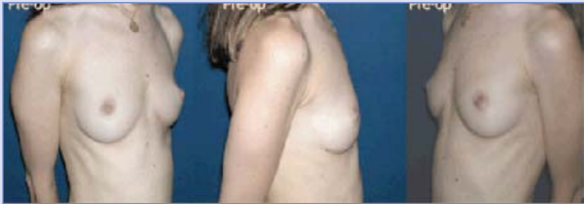
To obtain the implant base, subtract from the desired breast width (DBW) the breast parenchyma thickness (BPT).

Below you can find one of the clinical cases presented at the Forum:

Patient in her thirties looking to have a more natural looking breast, with an anatomical shape.

CLINICAL CASE

- 31 year old patient, medium height, true hypomastia
- Desires a projected but proportional augmentation, with more anatomical shape



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CLINICAL CASE

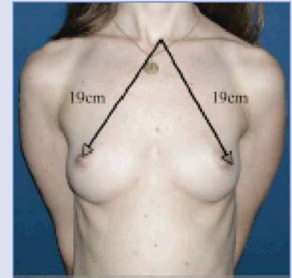
SN-N distance = 19cm

Desired base width = 14.0cm

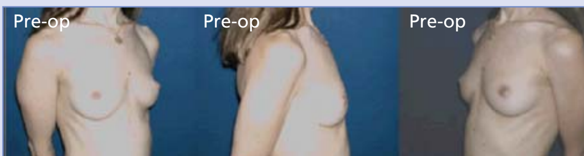
Breast thickness = 3.0 = 11.0cm

Implant Height = Moderate (Mx)

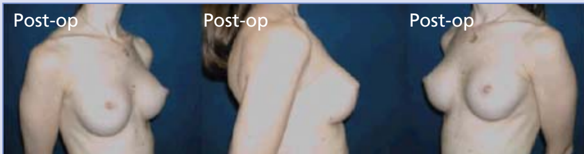
Projection = Full (xF)



In SN-N distance less than 20cm, select moderate height implants. In order to obtain the implant base, we shall substract from the desired breast width (DBW) the breast parenchyma thickness (BPT) obtained by the pinch test. The full projection implant was chosen due to the laxity of the skin envelope and patient's desire.



Implant 410 MF – Size 225g



INTERVIEW

Dr Rogerio Izar Neves, MD
Plastic Surgeon, Brazil

What are the different trends if you compare Brazil and the USA?

Unfortunately USA is 15 years behind Brazil in the breast implant market. In US the round silicone implants were released only on November 2006 and the anatomical breast implants with stable form cohesive gel were not yet approved by FDA. We have only 2 manufacturers in the market and if you use the implants from one of them you still have to fill extensive papers and forms to comply with the FDA regulations. Furthermore, there are grey areas in complying with such FDA regulations like the implants for breast augmentation can only be used in patients age 22 and up and patients need to be followed with MRI's after 3 years and every 2 years thereafter.

What would be your ideal measurement system? What would consist of?

Several good measurement techniques were designed by experts (J. Tebbets, P. Heden, Javier De Benito,). It will be very difficult to design all together a single consensus measurement guideline. However, by combining the strengths of each existing systems I developed a measurement guideline that works for me and my patients, allowing my residents to understand the concept of the dimensional augmentation or reconstruction, reproducible and easier to teach younger plastic surgeons a unique clear methodology to achieve the optimal breast surgery results.

The first step in the pre-operative planning process is to assess the breast/chest. Visual examination will help assess overall symmetry. Observe overall fullness – is it equal on both sides? Measure the distance from the suprasternal notch to nipple on both sides.

Taking accurate measurements is critical to ensuring a successful outcome and by far, the most important measurement is the breast base width. Failure to accurately measure the breast base width can result in selection of an implant that is too large which can cause a number of problems:

Rippling and folding; Over-stretching of the tissue; Visibility and palpability.

Measuring with calipers can give a much more accurate determination of the breast width.

The nipple to IMF distance (on stretch) is important to help you determine if the location of the IMF needs to be lowered. The final step in assessing the breast is to evaluate the soft tissue coverage. A visual assessment can give a good indication as to the degree of fullness. Evaluating the degree of elasticity will help determine if the volume of the implant needs to be adjusted. A tighter envelope typically requires less implant volume while a looser envelope usually requires more implant volume. Knowing the amount of parenchyma present is also important.

What would you say to a plastic surgeon that relies more on his/her "global visual" estimates than in a conducting measurements?

The dimensional approach rather than the volume estimate more clearly defines the patient's and surgeon's objectives. Makes surgical planning more logical, defining the height, width and projection that want to be reached. Includes objective measurements, enables refinement of operative plan being most decisions prior to go to the operating room and helps ensure outcomes that are more consistent, predictable and reproducible.

Have you had to adapt your measurement system from your practice in Brazil to the USA

The beauty of this system is that you can adapt it to cultural expressions of breast size, making easy to the patient understands what is a "proportional" breast augmentation and what is not. Almost all my patients understand this concept and opt for a more natural breast augmentation. However, if the patient still wants an oversized breast the concept can still be used but certainly the breast will not look natural and we will increase the chance of rippling and folding, over-stretching of the tissue and visibility and palpability of the implant.

Do you think there is a relation between the pocket size and the rotation of anatomical implants? What would for you be the solution to avoid this?

Absolutely yes, but this is not the only reason. An over dissected pocket increases the chance for rotation with any implants but specifically with the anatomical implants more than 10% rotation becomes readily noticeable. A sub clinical seroma is another reason for implant rotation.If not diagnosed can lead to a pseudo capsule formation between the implant and the outer capsule avoiding implant attachment. To avoid rotation of the implant make your pocket in the correct size, with traumatic dissection under direct view. Taping the breast with paper tape after the surgery may help to keep the implant in place with unnecessary movements. Some surgeons also systematically drain the cavity.

Do you perform any fat grafting to fine tune the breast shape? How would you distinguish later between the injected fat and the cancer cells?

No, I do not. Although is not difficult for radiologists distinguish between a calcification from a fat necrosis from micro calcification from breast cancer, I don't think we have already enough evidences to justify the procedure today. Maybe in the future if more consistent and multicentric data become available I will start to use it.

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