

# ISAPS<sup>®</sup> NEWS

OFFICIAL NEWS OF THE INTERNATIONAL  
SOCIETY OF AESTHETIC PLASTIC SURGERY

# 4

Volume 16 | Number 4



## INSIDE ■

Facial Fat Grafting  
Process: **How I Do It**

**Message from  
ISAPS' new President:  
Dr. Lina Triana**

**ISAPS Olympiad Athens  
World Congress 2023**

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# 2024

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# MESSAGE FROM

## the *ISAPS News* Editor-in-Chief

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ARTURO RAMÍREZ-MONTAÑANA, MD - MEXICO  
Editor-in-Chief, *ISAPS News*

Dear Colleagues and Friends!

This is our fourth and final issue of the *ISAPS News* Quarterly Magazine in 2022, and we have included some fantastic articles which I am sure all of you will enjoy.

This issue features a Practice Management article by Dr. Juan Esteban Sierra Mejía from Colombia, “Doctor, How Much Does Surgery Cost?,” which I strongly recommended.

We have two articles as part of our Culture section, the first one written by Dr. Pierfrancesco Cirillo, Italy, “Cosmetic Surgery and VAT: History of Prejudice And Discrimination”, and a second one written by Dr. Luiz Toledo, “The Future of Plastic Surgery.”

In our *ISAPS Travel* section read about, “Wine and Champagne in The Tropics? Venezuela’s Experience,” written by Dr. Douglas Narvaez Riera, *ISAPS National Secretary Venezuela*.

The December **How I Do It** section is on the facial fat grafting preparation process, an important aesthetic element that we encounter during our facial rejuvenation procedures. We received six fantastic proposals from different experts worldwide: Drs. Sergio Capurro (Italy), Mariam Tsvitsivadze and Marlen Sulamanidze (Georgia), Jesús Benito-Ruiz (Spain), Gustavo Abrile (Argentina), Richard Warren (Canada), and one from our Associate Member, Aneesh Suresh (India).

We are only a few days away from celebrating the end of the year; I don’t know if this pertains to some of you too, but every year I review my failures and achievements from throughout the year to obtain a “**final yearly balance**”.

I’m not talking only about the number of cases that I performed at the OR during the year, or even my bank account balance, but what I’m talking about is my “**personal-balance**”. Was I kind to my friends, how is my balance between being a brother, a father, and a partner? All these things represent “us”, and we have several **roles in life** at the same time that all require specific and unique needs.

We can be surgeons, employers, colleagues, neighbors, clients, guests, parents, and brothers, during our lives at the same time, but we must remind ourselves of the importance of having a “positive balance” in all the roles in which we are involved. These are not limited to only physical roles, but also deeper, more spiritual aspects that are more difficult to measure, like spirituality, mental health, and harmony. And I would like to wish all of you a “positive balance” for your “final yearly balance” as we close out 2022.

We are already gearing up for the ***ISAPS Olympiad Athens World Congress 2023***! This brand-new version of the academic gathering will be celebrated eight months from now, on August 31 through September 2, 2023.

The new concept will include a contest where the presenters will be judged by the attendees who will nominate the best presentations during the whole academic event. Let us have some fun and at the same time learn about the ultimate innovations in our specialty.

The 2023 program will be decided through a competitive abstract submission process, where abstracts will be considered for one of our Olympiad presentation formats: oral presentations (given alongside keynote sessions), rapid



communications, and electronic posters. There will also be a chance to compete for scientific awards in each subject category. If you want to participate, remember that the **ABSTRACT SUBMISSION CLOSES: January 31, 2023**. We hope to see all of you there. For more information on abstract submissions and to register, [click here](#).

Last but certainly not less important, on behalf of the ISAPS worldwide community, we want to congratulate our President, Dr. Lina Triana, who recently won Colombia's highest distinction of medical merit, the Medal Esculapio José Félix Patiño Restrepo. She was awarded this for her contribution to the medical profession, dedication to the education of future generations, the health of Colombians, and the environment. We all feel proud of this well-deserved achievement, congratulations Madame President.

As we finish the year, I wish you and your loved ones the best in your professional and personal lives. See you all in beautiful Athens, Greece!

Sincerely,



Arturo Ramírez-Montañana, MD  
Editor-in-Chief, *ISAPS News*





# MESSAGE FROM

## the ISAPS News Co-Editor

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FABIAN CORTIÑAS, MD - ARGENTINA  
Co-Editor, ISAPS News

## FOCUS ON OUR EDUCATION: THE BEST AND ONLY WAY TO BE LEADERS IN AESTHETICS

Dear Colleagues and Friends,

Due to many reasons, **continued medical education** is an important component of medical life for all specialties in general, and a fundamental necessity for aesthetic plastic surgeons in particular.

**Is it important to be informed about the new trends in the field?** Yes.

**Is it important to be up to date in the specialty?** Obviously.

**Is it valuable to have on hand as many alternatives as possible for each patient?** No doubt.

All these answers are exhaustive, in great part because during the consultation process or in the operating theater, we count with seconds or just minutes to bring out the best of us for the benefit of our patients. There is no time for hesitation.

Our Congresses offer a rich fountain of information and educational opportunities, for our members, like the last one in Istanbul. Members receive the latest findings within our specialty by way of a structured and organized scientific program, summarized by topic, which includes a wide spectrum of views/approaches on a given subject, and is delivered by the best plastic surgeons worldwide.

However, due to human limitations, we are unable to attend all the sessions that interest us, and therefore we miss out on a wealth of knowledge and updates.

However, all is not lost, as with today's technology, we have the option to "live the Congress once again", by **visiting the sessions we missed, or coming back to the ones we wish to revisit.**

As an attendee of the Congress, being able to go back to visit the program at any time we wish, is a technological wonder on one side, and a huge advantage for daily practice on the other. Our reality today, enables us to go back to a specific session or surgery and be present at a round table with masters anytime we want, and about the topic we need, when we need it.

The 2022 World Congress offered an unprecedented amount of useful information, encompassing all aspects of our practice. So, the next time you need assistance with a particular case, don't hesitate to go to the ISAPS website and select the appropriate session with the best experts in the field. You won't be disappointed. This is just one of many ISAPS membership benefits.



Alongside this new online educational advantage, ISAPS collaborates with other programs which are very successful and have been tested throughout the years, one of which is the [Visiting Professor Program](#) (VPP).

Due to the initiative of our President, Dr. Lina Triana, and under the supervision of the VPP Co-Ordinator, Dr. Renato Saltz, the list of professors was recently updated and renewed. The purpose of this program is to bring renowned educators in aesthetic surgery to regions worldwide, and offers the unique opportunity of hosting a plastic surgeon for several days and taking advantage of sharing their expertise with ISAPS members and residents. This is an exceptional experience, not only for our members and residents but also for spreading the ISAPS voice in your region.

As always, we look forward to your continued input, ideas, and article submissions, which all contribute to the advancement of ISAPS.

I hope you enjoy this December issue of our *ISAPS News* and have a good start to 2023!

Sincerely,



Fabian Cortiñas, MD  
Co-Editor, *ISAPS News*

# MESSAGE FROM

## the *ISAPS News* Co-Editor

---



**DIRK RICHTER, MD - GERMANY**  
Co-Editor, *ISAPS News*

Dear ISAPS Members,

I am very pleased to say hello to you today as the new Co-Editor of the wonderful *ISAPS News* quarterly magazine.

As a former President of ISAPS, I have always been excited about the development and opportunities to provide so much valuable information to our members.

The newsletter connects us to each other and provides us with the opportunity to develop professionally, and to pick up on the latest trends outside of academia.

It is not without reason that this publication is the most popular communication tool for our members. I am glad that I can now support this work, and that I can regularly bring you everything new, exciting, and worth reading about in our field and our professional Society.

If you have ideas or wishes to make this newsletter even better and more interesting, please [email me](#).

This issue is a typical and successful example of optimal member information. Our **How I Do It** section features several practical reports in the field of fat transfer, and we all know that the last word has not yet been spoken.

More research on this compelling topic is needed so that we continue to learn what the gold standard in fat transfer really is, and how this topic will develop.

Our Society is constantly progressing, and I look forward to what the upcoming year holds in store for us. In the meantime, we appreciate the shared knowledge from our valued and experienced members.

All the best to you for the upcoming holidays.

Sincerely,



Dirk Richter, MD  
Co-Editor, *ISAPS News* and  
ISAPS Past President (2018-2020)





# MESSAGE FROM

## the new ISAPS President

---

Dear Friends and ISAPS Members,

This December I was honored to receive, under the Pan American Doctor's Day, Colombia's highest distinction of medical merit: the Medal Esculapio José Félix Patiño Restrepo, which is awarded by the Colombian Medical College for contribution to the medical profession, dedication to the education of future generations, the health of Colombians, and the environment. I feel privileged to have received this direct recognition for my work in public health and patients' safety during the COVID-19 pandemic, but also grateful to reflect on the support and friendship I have received throughout my journey as a medical professional and now, with you, as your ISAPS President.

Thank you to our past leaders who envisioned the importance of putting us together: plastic surgeons from all around the world, for something bigger than ourselves. We were established in 1970 at the United Nations, and since then we have been constantly growing.

Today we have more than 5,000 members in 117 countries, with the base of our organization laying in our National Secretaries, our ambassadors to the world. And since unity gives us force, in these threatening days for our plastic surgery specialty, we created our **ISAPS Global Alliance**. This is a network of 88 scientific plastic surgery societies worldwide, working together because together we are stronger towards fulfilling our mission of delivering excellence in aesthetic education for the safety of our patients.

ISAPS is a unique organization in which we are a society of members and not of societies. This gives us added power since each and every one of us is here because we chose to be part of something bigger; we as part of the aesthetic world chose to belong to ISAPS.

Our purpose and vision as ISAPS is for safe and effective aesthetic procedures and improved quality of life for all patients worldwide. In order for us to achieve our

purpose, we must inspire and nurture excellence in aesthetic education worldwide for the safety of our patients; this is our ISAPS mission.

As your first Colombian President in the history of our organization, I can confirm that by taking action toward something bigger than ourselves, ISAPS as a society can make a difference.

I invite you all to recall why you decided to be a part of ISAPS, what your true purpose is, and ask yourselves in what group of membership you live your life today.

There are three kinds of members in organizations: The judging group, the automatic group, and the doers group.

I discovered this early in my career when, as a young, inexperienced plastic surgeon, I was full of energy and dreams, I entered the judging group where nothing happened. When you are in a judging mode, you find yourself on the sidelines, evaluating those that take action, but you are not really a part of the game.

Since we don't always see the changes happening, we tend to end up in the automatic mode, where we concentrate on our own practices, and rely on others to make big changes happen in the aesthetic world. However, if you really want things to change in your life, or in your specialty, you need to take action and enter the doers group.

Before starting our 2022-2024 ISAPS Board period, we sent a call to action to all members with an invitation to serve. I want to thank those that accepted our invitation, for taking action, and by doing so, being part of the ISAPS-created future.

For those that let this invitation pass them by, if you really want something to happen in our aesthetic world, it is not enough to stay in the judging mode. You need to raise your hand, take action and say, "Here I am, ready to serve."



Accepting the invitation to be part of ISAPS’ committees is the first step toward being part of an ISAPS-created future.

To this effect, advances have been taking place in the ISAPS committees, sub-committees, and focus group chairs. They have already built their own teams, which include ISAPS members that have shown the initiative to want to serve on a higher level within our Society. Even though some of you may not have been chosen to be actively involved in these groups, the possibility of being in action mode is still there. You can really serve ISAPS *by bringing us new options, and new possibilities on how to make things better.*

I am here to listen, but not to the situation per se (*I prefer to refer to it as situation and not problem*), but on how we can solve it. Who better than you, who are immersed in the day-after-day process, to identify the possibilities on how to make it better? And even though I am here to listen, that does not mean I will always be able to take immediate action, but by identifying a situation and sharing it, I will be aware of something that I did not realize was an issue, creating with our conversation a possibility for change.

To help ensure that our various committees and focus groups aim to achieve their active roles, we have distributed Terms of Reference (TORs). These are to serve as guidelines and help them really discover the **purpose** of what they have committed to in our organization. With this clarity, they have the tools to create the process on how to achieve this purpose.

To reflect and share my purpose, I can say that I started on this ISAPS leadership journey back in 2005 when I joined the Website Committee, and today I am the ISAPS President.

I ask you today, to reflect and see what kind of member mode you are following: judging mode, automatic mode, or doers mode.

**Because doers mode is the way leaders live.**

I invite you all to take action, be active towards a purpose bigger than yourself, be an active ISAPS member, and contribute towards who we are: **leaders in aesthetics.**

Thank you ISAPS members, **National Secretaries**, and the ISAPS Board of Directors (BoD) for believing in me and electing me as your President. And thank you to our previous BoD who believed in me and gave me the opportunity to chair our ISAPS Strategic Plan Committee where our 2021-2025 plan was created, together with our ISAPS BoD and National Secretaries.

With it, we created our ISAPS vision and mission that I shared with you above, as well as our ISAPS values and KPIs.



We can proudly say today that we have a solid administrative team under our new Executive Director, Sarah Johnson’s directive, and a great BoD which includes three women, something never seen before in ISAPS’ history.

Coming back to our strategic plan, and how to fulfill our ISAPS mission of inspiring and nurturing excellence in aesthetic education worldwide for the safety of our patients, as stated in our strategy document, some of our core activities include:





**1. Organize and Disseminate Aesthetic Education Worldwide.** We invite you all to create ISAPS educational opportunities in your respective countries. In future e-magazines, we will go more in-depth on what actions are needed from your side to create these educational opportunities.

**2. Promote Patient Safety.** Since ISAPS is here for safe and effective aesthetic procedures and improved quality of life for all patients worldwide, our Patient Safety Committee has been working very actively towards this purpose, our ISAPS vision. I invite you, if you have not done so yet, to look for our ISAPS Aesthetic Society Member Alert regarding the [US FDA Statement on Breast Implant Associated Squamous Cell Carcinoma \(BIA-SCC\)](#). Also, with the aim of supporting specific needs in our diverse ISAPS aesthetic world, we have endorsed the [Patient Safety Statement for Gluteal Fat Grafting](#) that the American Society of Plastic Surgeons (ASPS), The Plastic Surgery Foundation (PSF), The Aesthetic Society, and the Aesthetic Surgery Education and Research Foundation (ASERF) put together. Given the international nature of ISAPS and the different jurisdictions in which our members work, ISAPS will continue to review the international consensus and periodically update its position in this area as new information emerges.

**3. Protect our High Ethical Standards.** To implement this, during our past BoD meeting, we created an Ethics Committee, and are in the process of putting together its TORs.

**4. Publish High-Quality Research** is one of our core activities where the *Journal Aesthetic Plastic Surgery* (APS), our forum for original articles advancing the art of aesthetic plastic surgery, is our source for sharing research. We want to give a special acknowledgment to Dr. Bahman Guyuron, the Editor-in-Chief of APS, for his hard work in enhancing the quality of our ISAPS Scientific Journal. I hereby want to share with you that our Journal Operations Committee is looking for new possibilities for our APS journal.

**5. Communicate our Work Broadly within and Beyond our Specialty.** To develop this area, we are currently working with our communications team on a strategy document with which we can enhance our current communications.

Based on ISAPS' vision, our purpose for safe and effective aesthetic procedures, and improved quality of life for all patients worldwide, I want to ask each and every one of you, "What actions are you taking towards fulfilling it?" It is clear that the aesthetic world in which we all live faces critical threats against quality aesthetic plastic surgery procedures, which are paramount for the safety of our patients. Therefore today, I want to bring back our ISAPS Safety Diamond based on our four pillars:

1. The **surgeon** who performs the procedure: must be board certified in plastic surgery or the country's equivalent, and have the knowledge, training, and experience to do what he/she says they will do for the patient.
2. The **facility** where the procedure is performed: the environment where the procedure is being done complies with the regulatory requirements.
3. The **patient** to whom the procedure is being performed: that the patient's conditions are optimal for the procedure that is being done.
4. The **procedure**: this is decided after the surgeon first listens and then examines the patient, so afterward, a joint treatment plan is created, including what procedure will be done, and what supplies and medical devices are to be used to perform the surgery.

As doctors, the rest of our health team and even our patients grant their leadership to us, which just comes naturally, and with it, a huge responsibility. Therefore for ISAPS, safe and effective aesthetic procedures, and improved quality of life for all patients worldwide, is a priority.

As leaders of the team, we start to develop management skills throughout our professional life. This is something that we are not formally instructed on, it is inherent. And as doctors, we put a lot of emphasis on the importance of increasing our knowledge and technical skills throughout our careers, what we call "hard skills". So, it is difficult



to believe that, according to a study held by Harvard University, only 15% of being successful in our careers comes from these hard skills, and the rest of our career success, 85%, stems from the development of our soft skills, where leadership has a protagonist role.

It is no wonder why we are losing this “granted” leadership with our patients. Maybe this is also why there is a crisis of legitimacy in our authority figures, in government, in the police force, in organized human entities, and society in general, because we are living during times when there is a lack of *true* leadership. This guidance and influence unite individuals around matters of fundamental interests where they can all significantly contribute “as one” and express themselves for something bigger than themselves.

Learning soft skills with today’s conventional way of teaching does not necessarily make you a leader. Listening to your successful peer and getting his/her tips on how he/she got to be successful does not necessarily guide

you to being a successful person, it just accumulates knowledge, but does not provide you with the assets of *being* a leader.

So, I would like to remind each and every one of you, that you are leaders in aesthetics, in your micro surroundings and your own aesthetic world. And this personal aesthetic world is just a part of the broader picture of the entire aesthetic world, which consists of your national society, fellow members, and being part of ISAPS. These are what give you the opportunity to be part of the **global aesthetic world**.



Lina Triana, MD  
ISAPS President, 2022-2024



# MESSAGE FROM

## the Education Council Chair

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OZAN SOZER, MD - UNITED STATES  
Chair, ISAPS Education Council

Dear ISAPS Members,

I am honored to be appointed as the Educational Council (EC) Chair for another term by our President, Dr. Lina Triana. My first term ended at our Biennial Meeting in Istanbul, and I am very happy to announce that the Istanbul meeting was very successful. We had over 1,500 onsite registrations, and close to 400 faculty presented their outstanding work.

The new EC consists of a larger team than the last term, with Dr. Francisco Bravo still acting as the co-chair. We also have a Journal Club Committee, chaired by Dr. Jerry O'Daniel, and a Residents' Education and E-Learning Committee, led by Dr. Gustavo Abrile.

We already had our first Journal Club meeting this past November, and we will continue every other month. Dr. Abrile is working on our virtual Resident Webinars, which are also planned to take place every other month, alternating with the Journal Club.

The **Visiting Professor Program** has also become part of the EC's responsibility, and Dr. Carlos Roxo will be visiting the Dominican Republic in February 2023 as part of this program.

Next year, for the first time, we will organize the **ISAPS Olympiad Athens World Congress 2023**, which will take place from August 31 to September 2, and will have a different structure than our traditional biennial meetings. We will have approximately 60 invited faculty which were chosen by our members as top presenters during the Vienna and Istanbul meetings. The rest of the meeting will consist of our members presenting their work, chosen by a competitive, peer-reviewed abstract submission process. Additionally, the best presentations will be recognized and awarded.

We are also excited to announce our new Biennial Meeting which will take place in Cartagena, Columbia in June 2024, with over 400 expected faculty presenting. We are considering sessions in Spanish and Portuguese, with English translation, to give the opportunity for non-English speaking presenters to showcase their work.

In addition to these activities, we will have our **3rd Annual Periorbital and Facial Symposium** in Atlanta, GA, US, on January 26, 2023, which is a combined effort by ISAPS and SESPRS. ISAPS is also hosting a course about body and breast surgery in Kuwait City, Kuwait, in March 2023. ISAPS will also put together a facial mini-symposium in Miami, FL, US as part of the **Annual Meeting of the Aesthetic Society** on April 22, 2023.

As Chair of the Educational Council, I am confident that our new team will work hard to provide the best aesthetic education in the world. I look forward to seeing many of you next year.

Sincerely,



Ozan Sozer, MD  
Chair, ISAPS Education Council



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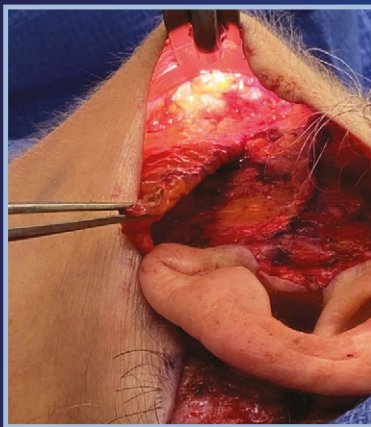
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Kazakhstan Society of Aesthetic and Plastic Surgery (NSAPS)
44. **KOREA, SOUTH**  
Korean Society for Aesthetic Plastic Surgery (KSAPS)
45. **KUWAIT**  
Kuwait Society of Plastic Surgeons (KSPS)
46. **LATVIA**  
The Latvia Plastic Surgery Society (LPSS)
47. **LEBANON**  
Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery (LSPRAS)
48. **MACEDONIA, NORTH**  
Macedonian Association of Plastic, Reconstructive and Aesthetic Surgeons (MAPRAS)
49. **MALAYSIA**  
Malaysian Association of Plastic, Aesthetic and Craniomaxillofacial Surgeons (MAPACS)
50. **MEXICO**  
Asociación Mexicana de Cirugía Plástica Estética y Reconstructiva (AMCPER)
51. **MOROCCO**  
Société Marocaine des Chirurgiens Esthétiques Plasticiens (SOMCEP)
52. **NETHERLANDS**  
Nederlandse Vereniging voor Esthetische Plastische Chirurgie (NVEPC)
53. **NICARAGUA**  
Asociación Nicaragüense de Cirugía Plástica (ANCP)
54. **NORWAY**  
Norwegian Society for Aesthetic Plastic Surgery (NSAPS)
55. **OMAN**  
Omani Society of Plastic, Reconstructive and Aesthetic Surgery (OSPRAS)
56. **OSAPS**  
Oriental Society of Aesthetic Plastic Surgery (OSAPS)
57. **PAKISTAN**  
Pakistan Association of Plastic Surgeons (PAPS)
58. **PANAMA**  
Asociación Panameña de Cirugía Plástica, Estética y Reconstructiva (APCPER)
59. **PERU**  
Sociedad Peruana de Cirugía Plástica (SPCP)
60. **PHILIPPINES**  
Philippine Association of Plastic, Reconstructive and Aesthetic Surgeons (PAPRAS)
61. **POLAND**  
Polish Society of Plastic, Reconstructive and Aesthetic Surgery (PSPRAS)
62. **PORTUGAL**  
Sociedade Portuguesa de Cirurgia Plástica Reconstructiva e Estética (SPCPRE)
63. **QATAR**  
Qatar Society of Plastic Surgery
64. **ROMANIA**  
Romanian Aesthetic Surgery Society (RASS)
65. **RUSSIA**  
Northeastern Society of Plastic and Reconstructive Surgeons (NESPRS)
66. **RUSSIA**  
Russian Society of Plastic, Reconstructive and Aesthetic Surgery (RSPRAS)
67. **SAUDI ARABIA**  
Saudi Plastic Surgery Care Society (SPSCS)
68. **SERBIA**  
Serbian Society of Aesthetic Plastic Surgeons (SRBSAPS)
69. **SERBIA**  
Serbian Society of Plastic, Reconstructive, and Aesthetic Surgery (SRBPRAS)
70. **SINGAPORE**  
Singapore Association of Plastic Surgeons (SAPS)
71. **SOUTH AFRICA**  
Association of Plastic, Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA)
72. **SPAIN**  
Asociación Española de Cirugía Estética Plástica (AECEP)
73. **SPAIN**  
Sociedad Española de Cirugía Plástica Reparadora y Estética (SECPRE)
74. **SWEDEN**  
Swedish Society of Aesthetic Plastic Surgery (SFEP)
75. **SWITZERLAND**  
Schweizerische Gesellschaft für Ästhetische Chirurgie (SGAC)
76. **SWITZERLAND**  
Swiss Society of Plastic, Reconstructive and Aesthetic Surgery (SSPRAS)
77. **TAIWAN**  
Taiwan Society of Aesthetic Plastic Surgery (TSAPS)
78. **TAIWAN**  
Taiwan Society of Plastic Surgery (TSPS)
79. **THAILAND**  
Society of Aesthetic Plastic Surgeons of Thailand (THSAPS)
80. **TURKEY**  
Turkish Society of Aesthetic Plastic Surgery (TSAPS)
81. **UKRAINE**  
Ukrainian Association of Plastic, Reconstructive and Aesthetic Surgeons (UAPRAS)
82. **UKRAINE**  
Ukrainian Society of Aesthetic Plastic Surgeons (USAPS)
83. **UNITED ARAB EMIRATES**  
Emirates Plastic Surgery Society (EPSS)
84. **UNITED KINGDOM**  
British Association of Aesthetic Plastic Surgeons (BAAPS)
85. **UNITED KINGDOM**  
United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)
86. **UNITED STATES**  
American Society for Aesthetic Plastic Surgery, Inc. (ASAPS)
87. **VENEZUELA**  
Venezuelan Society of Plastic, Reconstructive, Aesthetic and Maxillofacial Surgery (SVCPREM)
88. **VIETNAM**  
Vietnamese Society of Aesthetic and Plastic Surgery (VSAPS)







# FEATURE: HIGHLIGHTS FROM THE 2022 ISAPS WORLD CONGRESS



## ISAPS WORLD CONGRESS ISTANBUL 2022 - POST CONGRESS REPORT

Our 2022 World Congress in Istanbul was a remarkable success, and we want to thank everyone involved as well as all of our participating members! We had over 2,000 plastic surgeons from more than 100 countries in attendance!

The Education Council prepared one of the most comprehensive scientific programs in aesthetic plastic surgery history. The Congress featured 400+ faculty, 47 master classes, 23 keynote lectures, 12 meet-the-expert sessions, diverse trending topic panels, a focus on regenerative surgery, and, for the first time, two full days of non-invasive surgery sessions, including the ISAPS Business School.

As we wrap up 2022 and prepare for 2023, please join us as we take a moment and look back on the success in Istanbul and look forward to next year.







47 MASTER CLASSES

WATH

October 2, 2023

23 KEYNOTE LECTURES

12 MEET-THE-EXPERT SESSIONS

400+ FACULTY





# COMMITTEE REPORT

## ISAPS Governance & Ethics Committees

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**IVAR VAN HEIJNINGEN, MD - BELGIUM**  
Chair, ISAPS Corporate Governance and Policy Committee



**KAI KAYE, MD - SPAIN**  
Chair, ISAPS Ethics Committee

## THE CHALLENGE OF ETHICS IN THE FIELD OF COMPETITIVE MEDICINE

Part of being a Board of Director in our Society means that we are not only responsible for our daily duties and tasks but also for governance. Part of governing means that we are often challenged by the social-ethical behavior of some of our members who fall behind the high expectations that all of us should exhibit as part of the ISAPS community.

These cases include plagiarism of content from the websites of other members, colleagues misusing their position, using ISAPS channels to market their private ventures, or simply members being reported for allegedly unethical behavior by patients.

In this respect, how we deal as a society of peers with these issues is an extremely important socio-cultural aspect of **Good Governance**. It not only reflects how we interact with each other in ISAPS as plastic surgeons but also how we behave as doctors in our community with our colleagues and with our patients.

To this end, we have elected to task our Trustee, Dr. Kai Kaye, to Chair a new Ethics Committee, and this newsletter focuses on the challenge of ethics in the field of competitive medicine, such as plastic surgery.

### HIPPOCRATIC OATH

When it comes to mentioning ethics in the context of medicine, the first thing that comes to mind is the Hippocratic Oath, traditionally attributed to the greek physician Hippocrates

(460-370 BC). While most physicians nowadays most notably remember the famous, “primum non nocere” (first do no harm), and see it as the main directive for their actions with their patients, the first versions of the original text didn’t contain this phrase, but reflected on more ample intentions that are vowed by, “I will abstain from ALL intentional wrongdoing and harm”.

The main directive to “do no harm” may already be under serious ethical questioning, but when it comes to valuing all implications of modern high-tech medicine in our patient’s life, or especially the impact of certain aesthetic procedures that we as plastic surgeons perform on a daily basis on healthy clients that become our patients, I do see a serious challenge ahead for a general claim of abstinence of intentional wrongdoing in our field.

Modern medicine has developed and spread enormously in its methods, applied sciences, and knowledge, but consequently, it is no longer the ancient healing art that it was when the oath was coined between the 5th and 3rd century BC when doctors were rare, and patients often had to travel days to even find one scholar of medicine.

### COMPETITION

Competition as we know it today, simply was not an issue for ancient scholars, especially in our field. It has become more and more obvious that it has evolved into an ethical issue



worthy for medical societies to discuss what is “intentional wrongdoing” towards peers and patients, and what is acceptable behavior in the context of capturing a patient, or in relation to a colleague.

Criticism about colleagues has, rightfully or not, formerly been voiced only in the privacy of a personal office consultation. However, today we find dozens of online “patient information” portals where even respected members of our community comment publicly on cases, or pictures of dissatisfied patients seeking an opinion on whether their outcome with another colleague was acceptable or not.

The global dissemination of our medical acts via social media, digital platforms, and websites, leads to an overflow of information and a general dilution of our own specific, individual qualities. This results in the ever-growing desire to stand out from the masses of our peers by either being more drastic or dramatic in presentation, sometimes with gruesome videos, or by self-declaring oneself as being “the best” in something. This affinity is affirmed by fake media prizes and awards and by untruthful, or simply misleading “before and after” pictures, that visualize a less common, exceptional result as a standard outcome of a treatment which in most cases may be much less impressive or convincing.

**ETHICS**

That alone is enough mental stimulation for critical and ethical thinking, but it sometimes gets worse with plagiarism, as pictures, website content, and even presentations at our meetings, are often copied or filmed, relabeled, and reposted by some colleagues as their own material.

Often, all of these actions are clearly intentional with the purpose of capturing more patients, achieving more online fame, or recruiting more followers, leaving the question of, “To what extent are these measures still compatible with the original intent of the first code of conduct that the medical profession aspired to 2,500 years ago?”

Humanity and civil societies evolve, which they must, and we as a scientific society must develop as well if we don’t want our codes and core values to be perceived as outdated, and therefore silently ignored.

**NEW CODE OF ETHICS**

Therefore, we will have to develop an updated version of our current ethical codex, a codex that still protects our core beliefs of how collegial and ethical interaction between peers should be, but also considers the challenges of the rapidly changing professional environment from the last generation of plastic surgeons to the present and succeeding ones.

This new code will not be centered only on the professional relationship between patients and surgeons as a core value of our organization, but it must also be broadened to encompass the progressive intercollegiate and competitive aspects of aesthetic surgery in this digital century, to provide fair and balanced guidance and to our members.

This will be the first task of the newly founded Ethics Committee of ISAPS, to oversee the reformulation of our codex and to implement it into the core of our Society’s vision, that all our worldwide members proudly share.

Sincerely,



Ivar van Heijningen, MD  
Chair, ISAPS Corporate Governance and Policy Committee



Kai Kaye, MD  
Chair, ISAPS Ethics Committee



# ISAPS JOURNAL

## MESSAGE FROM THE EDITOR-IN-CHIEF



**BAHMAN GUYURON, MD, FACS - UNITED STATES**  
Editor-in-Chief, *Aesthetic Plastic Surgery*

Dear ISAPS Members,

Those of you who attended this year's World Congress would agree that the ISAPS Education Council, under the direction of Dr. Ozan Sozer, offered a fantastic scientific program in Istanbul. It was wonderful seeing everyone, and the program benefited those attending the meeting in person, or virtually, to an equal measure.

The byproduct of this meeting was the surge in submissions of the presented articles to our Journal, which in turn demands more help from the reviewers. Our need for additional reviewers with experience in the areas of oculoplastic, genital, and gender reassignment surgeries persists. For those of you who are interested in helping us, all you need to do is send your full name, email address, and the topic of interest directly to me at [bguyuron@guyuron.com](mailto:bguyuron@guyuron.com). Those of you who are currently reviewers and know of other interested individuals who have expertise in these areas, and are willing to do so, please send me their names and email addresses.

Review of the articles was one of the most enjoyable academic activities for me in the early stages of my career. You get to learn about new developments before anyone else, help in deciding the scientific merits of an article, and accept or reject the submitted manuscript. I generally do not send more than one new article a month to each reviewer, including the Editorial Board members. However, while the reviewers are assigned to review a new article, they may also get a previously revised article to make sure that the recommended emendations have



been implemented. The latter should not take more than a few minutes of the reviewer's time.

The last issue of the Journal was larger than what I would have liked, since we had a large backup of articles that needed to be published to prevent delay in fulfilling the desire of the authors who were waiting for the publication of their articles for a long time. You will note a reduction in the volume of the Journal, in addition to some other improvements, in future volumes.

While we enjoy the progress that we have made with the Journal, we are still not content. We are engaged in serious conversation with the Journal's publisher

about the improvements that we have envisioned, and are optimistic that we will get the Journal to where it should be in all aspects.

As we near the end of 2022, I want to extend my deepest gratitude to the members of our Editorial Board and so many of you who have submitted articles or served as reviewers. Our Journal would not have made the strides that it has without your volunteered time and energy.

Sincerely,

**Bahman Guyuron, MD, FACS**  
Editor-in-Chief, *Aesthetic Plastic Surgery*





# ISAPS OLYMPIAD ATHENS WORLD CONGRESS 2023 - ATHENS CHAIRS, DR. APOSTOLOS MANDREKAS, AND DR. VAKIS KONTOES, SHARE WHAT WE CAN ANTICIPATE



**APOSTOLOS MANDREKAS, MD - GREECE**  
ISAPS National Secretary



**VAKIS KONTOES, MD - GREECE**  
ISAPS Board of Directors, Secretary

As we start preparing for our next World Congress in Athens, August 31 to September 2, 2023, we are excited to announce a new innovative concept for next year: the invited lecture program has been decided by you, and our main session speakers will be curated from your best abstract submissions.

Our initial invited faculty have been chosen as 'best-rated' speakers across all ISAPS events over the last two years according to the delegate ratings, and the last 15 have been voted at this year's Congress in Istanbul. Your input will help form selected keynote discussions and session topics derived from the paper submissions from you, our members, who play such an integral part in our event.

We recently had the opportunity to discuss the 2023 program with our Congress Chairs to learn what we can expect.

## **1. ISAPS' last Congress was a great success; what is being done for next year to keep up the exciting momentum, and what can attendees anticipate seeing on the 2023 program?**

**Mandrekas:** The Istanbul Congress was a great success, and my friend Dr. Nazim Cerkes raised the bar high. The module of the Olympiad Athens World Congress program will be quite different. It will be *your* Congress and, apart from a small number of invited faculty, the rest of the program will be dedicated to the participants to present their work and their experience.

**Kontoes:** ISAPS is organizing a new format for the World Congress, the ISAPS Olympiad. The momentum after the last successful Congress is indeed very exciting, and we hope that the Olympiad Athens World Congress will build on this excitement, by giving the podium to our members to present their work, compete for scientific awards, and most importantly to come together again to share great scientific and social activities.

## **2. As part of the unique program in Athens, presentations will be selected from a competitive, peer-reviewed abstract submission process. Explain how this process works and how the final presentations are decided.**

**Mandrekas:** The Education Council has decided that there will be a committee of very well-known and respected peer reviewers that will decide which abstracts will be accepted in each category for lectures, posters, and short communications.

**Kontoes:** We have reviewed the most popular topics from the past years and suggested submission topics accordingly on: aesthetic surgery, non-invasive or minimally invasive techniques, patient safety, Business School, and sub-categories of these topics. We will accept abstract submissions from our members from now up until January 31, 2023, and these abstracts will be peer-reviewed and scored, with the best being allocated to our main program sessions and presented alongside our keynote presentations,



as well as into free paper rapid communication sessions. All accepted abstracts included in the 2023 program, as well as abstract supplements, will be eligible for awards in each topic category. In this way, the Olympiad format aims to further improve the quality of our program and to create a program made by and for our members: both by having suggested the keynote speakers and by having the opportunity to present their work in the program.

**3. In terms of live surgery presentations, what can attendees look forward to in 2023? Are there any plans to develop this portion of the event?**

**Mandrekas:** The decision is to have one day with video sessions where the presenters will be present and provide discussions with the audience. This will give attendees an opportunity to see the surgery and ask questions or make comments.

**Kontoos:** Yes of course. We will have a pre-Congress day where we will include a video surgery session. The most prominent speakers ranked highest in live surgery events in the last three years, will present their techniques on videos commenting on step-by-step procedures. This will induce better interaction between the speakers and the attendees, who will be present during the video presentation, and reply to questions from the floor.

**4. New for next year are the awards for best presentations. These are to be selected by the Congress audience and Scientific Committee and presented in all categories during the Olympiad ceremonies onsite in Athens. As a potential winner, what can participants expect from these awards?**

**Mandrekas:** There will be nine categories of topics, including but not limited to, face, breast, body, etc., and each category will be awarded a gold, silver, or bronze medal and a certificate. In addition to that, most of the papers will be published in a special edition of the *Journal Aesthetic Plastic Surgery*.

**Kontoos:** Winners will be awarded with gold, silver, and bronze medals, certificates of appreciation, and be eligible as faculty for future events in the 2024/2025 World Congresses, and also publication of their work in the *Journal Aesthetic Plastic Surgery*. Residents' winners will additionally be eligible for stipend awards.

**5. As a dedicated member of ISAPS, what would you say is one of the most beneficial factors of being a part of this Society, and why is the Annual Congress such a paramount event?**

**Mandrekas:** I have been a member of many national and international societies during my 40-year career in plastic surgery. I can assure you that the most active one is ISAPS, and I have enjoyed being a member of this Society. The Annual Congress brings the members together and facilitates learning from others which is especially important since aesthetic surgery changes rapidly every year. ISAPS also provides the opportunity to meet international friends, make new ones, and finally, visit new places every year.

**Kontoos:** I believe that the most beneficial factor of being a part of this Society is the unparalleled opportunity of updated education through the numerous and different modalities offered to members by ISAPS. Our mission is "Aesthetic Education Worldwide" and ISAPS honors this mission extensively, spending and investing towards it through online learning, virtual, hybrid and live events. This is what makes every Annual Congress a paramount event. The fact that, in line with the educational mission of ISAPS, the best of the best gather to share experiences and updated knowledge with our members, to upgrade and support patients' safety, and spread the message around the world that ISAPS members are the **leaders in Global Aesthetics**.

**6. At this year's past Congress, the Residents' Symposium focused on facial rejuvenation and breast surgery; what can residents expect from the ISAPS Olympiad Athens World Congress?**

**Mandrekas:** One of ISAPS' scopes is education and we will try to focus on that during the Olympiad Athens World Congress. Not only to educate young residents, but also to allow them to present their work and be part of the educational program. The Education Council will also be there to listen to their feedback and suggestions.

**Kontoos:** The Olympiad Athens World Congress will have a dedicated Residents' Symposium to be held during the pre-Congress day with topics that will be included in the program in accordance with the abstracts that will be submitted and accepted by the residents.



**7. Out of all the ISAPS Congresses, Symposia, and Courses that you have attended, what has been the most memorable? And what are you most looking forward to in Athens?**

**Mandrekas:** During my long career, I have attended and acted as a faculty member of many Symposia, Courses, and Congresses in different countries and across all continents, but I don't want to be unfair to any of those because all the organizers have put in a lot of effort and energy for successful meetings. The Olympiad Athens World Congress is quite different and offers a new module which I'm sure attendees will like and support.

**Kontoes:** The educational journey with ISAPS has offered me a lot. Learning, friendships, exchange of ideas and knowledge, visits to amazing locations, and I have had the chance to meet and work with people of different customs and cultures all around the world. It would be unfair to select one as the most memorable since each one of them offered something different. I thank them very much for honoring me with their friendship and support as part of this great global family over many years. In Athens, I am looking forward to being part of another innovative ISAPS activity, especially our scientific awards which are completely new for this year. I am looking forward to a unique and successful event more closely supported by our members' input into sessions, and to hear their contributions, to make the first ISAPS Olympiad a World Congress to be remembered and become the paradigm for the future Olympiads which will come in the future.

**8. Finally, what can attendees look forward to in terms of the social and networking element of their time in Athens?**

**Mandrekas:** Greece, and especially Athens in the summer, is a destination for everyone. It is a great opportunity for participants to combine the Congress with their summer holidays, not only in Athens but also at the Greek Islands. So, bring your family with you and enjoy the Congress and the Greek hospitality. See you all in Athens!

**Kontoes:** Athens is a vibrant city full of history, philosophy, and modern culture. The attendees of the Olympiad can find everything they could imagine. Starting from visiting the ancient monuments and sites of the city for a trip to the ancient Greek era and its philosophy as the cradle of democracy, a 'must visit' to the Parthenon and the Acropolis Museum, the renovated National Gallery, the National Museum and ending with amazing dining choices, shopping, or wonderful trips to the Saronic Bay Islands close to the Athenian Riviera. Unparalleled night life, diverse cuisine, day trips to the surrounding mountains with incredible views of the city, and a lot more. Not to forget the easy access to the picturesque islands of the Aegean Sea which await its visitors for unforgettable experiences and holidays during an excellent climate, like the one expected at the end of August.

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## CALL FOR PAPERS

Sixty keynote faculty members have already been chosen by you and invited as our best-ranked speakers from the last two years of ISAPS events. The rest of our program of speakers will be selected from your submitted papers, so please do share your work: new techniques, innovations, research studies, case reports, or critical state-of-the-art updates are all welcome, and will be considered for presentation in our main program sessions.

**Please submit your abstracts here now**, before January 31, to be part of our program. Submission is open to any plastic surgeon: whether you are a regular ISAPS speaker or a newly-qualified surgeon, your work will be considered. Best presentation awards will be presented in all topic categories and our winners will be acknowledged in the official ISAPS Journal and receive invitations to speak at our next World Congress in Cartagena, Colombia. Best papers from residents are also eligible for stipend awards.



# PRACTICE MANAGEMENT

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**JUAN E. SIERRA MEJÍA, MD - COLOMBIA**  
ISAPS National Secretary

## DOCTOR, HOW MUCH DOES SURGERY COST?

Many times I meet colleagues who want to improve their professional performance and have more balance in their personal and work life. I find a frequent question among them, “How to respond to patients who ask, ‘What is the price of surgery?’”

Nowadays, the presence in social media is very important for the visibility of our services. It helps acquire new patients, increases word-of-mouth referrals, and provides visibility to a large audience. Unfortunately, a reiterative question is about the price of the procedures, and whether it is true that we could give them a fixed price in the initial consultation, but it is very important that we can create an ongoing relationship with that potential patient, and be able to show them everything we can offer. This differentiates us by showing our real value and perhaps affirming that the price becomes secondary. By doing this, we will have patients who are willing to pay much more than they expected to pay in the first place, and perhaps even put ourselves a step above the prices of other surgeons.

In order to know how much to charge for a service, we must consider a number of variables that we commonly do not take into account. We exchange time for money, so how much does your work cost per hour? In our environment, it is possibly quite difficult to define this amount. It would be a mistake to compare what a specialist could charge as opposed to how much an employee earns because as an employee, one does not have to think about the resources needed to provide a service as an independent doctor. Certainly, the expenses will

be much higher, and depending on the type of patient we seek, these can have great variability.

On the other hand, we must differentiate price from perceived value. What is the benefit that our patient is going to have, what does this mean for them, and how much would they be willing to pay for the benefit that they are going to receive?

In order to ascertain a specific cost, the first thing we should do is a cost analysis. We should even include intangible variables such as effort, expertise, custom experience, or time spent providing the service, along with absolutely quantifiable costs such as office rent, or personnel expenses.

Once we have the cost per hour with all the variables considered, we can even go to the next level and think about the added value, which is the customized and unique experience we provide for our service, which is what turns it into a superior experience. This gives us more freedom to command the higher, prestigious prices that we dream of. Only individuals and companies that manage to differentiate themselves and position themselves with some important attributes for consumers, will be able to charge higher prices, and these prices, in turn, may be representative of the quality of the service offered.

If we hire the services of a professional in any field, there is an expected result that is the benchmark of what anyone would get, but how can we achieve something more? We should not only be valued by the results



obtained by the professional but also by the treatment received, whether there is empathy, prompt information, kindness, good service, etc. It is in this area, that we can be creative in finding different approaches how to persuade a potential patient.

One of the basic aspects that we must work on to achieve this, is to work on our *personal brand*, a subject that we have dealt with in previous articles. Only in this way, will we be able to start a meaningful career in which we can become more than a commodity, and become a service of excellence for which we can charge what we may never have thought would be possible.

We are entrepreneurs who manage a business so that *it* adapts to *our* lifestyle, and not so that the business manages *us* and we have to adapt *our lifestyle to the business*.







# ISAPS® ENDORSED SAFETY STATEMENT

## STATEMENT ON PATIENT SAFETY DURING GLUTEAL FAT GRAFTING ENDORSED BY THE INTERNATIONAL SOCIETY FOR AESTHETIC PLASTIC SURGERY (ISAPS), AMERICAN SOCIETY OF PLASTIC SURGEONS (ASPS), THE PLASTIC SURGERY FOUNDATION (PSF), THE AESTHETIC SOCIETY, AND THE AESTHETIC SURGERY EDUCATION AND RESEARCH FOUNDATION (ASERF)

### BACKGROUND

Gluteal fat grafting, commonly known as “Brazilian Butt Lift” or BBL, has seen an increase in popularity in recent years. It is well-recognized that this procedure carries significant risk compared to other elective aesthetic surgical procedures<sup>1,2</sup> and as a result, its increased popularity has resulted in deeply concerning levels of patient harm and mortality. While statistics are difficult to obtain, there is no question that gluteal fat grafting patients are experiencing abnormally high levels of complications and that fatalities from fat embolisms<sup>3,4</sup> are occurring with disturbing frequency.

In 2018 and 2019, two multi-society safety advisories raised awareness of the risks associated with gluteal fat grafting and called on our members and the public to approach the procedure with extreme caution<sup>5,6</sup>. Following those advisories in the United States, the Florida Board of Medicine mandated new standards of care for gluteal fat grafting that sought to reduce patient harm by requiring that fat be injected only into the subcutaneous space, above the gluteal fascia.

Recently, the State of Florida instituted additional emergency rules limiting gluteal fat grafting procedures to three per day and requiring the use of ultrasound to monitor the location of the tip of the cannula while fat is injected. Our Societies support these patient safety measures and believe that they are likely to save lives and reduce morbidity. We hope that further scientific study will demonstrate that the measures adopted in Florida achieved their intended purpose, but we stand ready to do more and reconsider approaches if they do not.

Our Societies acknowledge and commend the significant actions taken to date in the United States and internationally to improve the safety profile of this procedure.

### POSITIONS ON GLUTEAL FAT GRAFTING

Given the international scope of this problem, the Executive Committees of our Societies have adopted several positions with respect to gluteal fat grafting as critical to the overarching pursuit of gluteal fat grafting safety.

#### 1. Training, Credentialing and Privileging Standards.

Gluteal fat grafting, like any plastic surgery procedure, when performed in an office-based setting, should only be performed by surgeons who have privileges to perform that surgical procedure in a country- or state-approved or licensed ambulatory surgery center or hospital.

#### 2. Real-Time Ultrasound-Assisted Gluteal Fat Grafting.

Public policy interventions targeting surgical gluteal fat grafting techniques are appropriate given the patient safety emergency that currently exists. As an adjunct to the skill and judgment of a qualified surgeon, real-time imaging during gluteal injection is a common-sense step toward ensuring that surgeons are staying above the fascia of the gluteal muscles<sup>7,8</sup>. Our Societies are committed to ensuring members are appropriately proficient in ultrasound technique and will work to develop best practice guidance and educational opportunities for members related to the safe provision of gluteal fat grafting. We support mandates by official governing regulatory bodies to require the use of ultrasound to ensure delivery of the fat graft in a safe anatomic plane.



**3. Pre- and Postoperative Care and Oversight.** Surgeons should be actively engaged with their patients before surgery and establish a doctor-patient relationship. Surgeons should manage both standard post-operative care and be available to manage all complications for their patients. This should be the case whether the patient is local or has traveled from another country or state to undergo the procedure. Surgeons who treat patients at a distance need comprehensive pre- and postoperative clinical care protocols and should be available to directly provide care or participate in managing post-op complications.

**4. Ethical Facility Operations.** Business operations of some facilities performing gluteal fat grafting represent an area of serious concern. Untrained or under-trained surgeons or non-surgeon operative assistants should not perform critical portions of a gluteal fat grafting procedure, including both injection of fat as well as the lipo harvest. Member surgeons of our Societies should not practice in facilities that engage in this conduct and should follow the specialty's position statement on concurrent surgery<sup>9</sup>. Business models that endanger patients in the pursuit of profits should not be tolerated, and our Societies support those practice models that truly prioritize patient safety and quality outcomes. Concerns over a high number of cases per surgeon/per day have been raised by certain states relative to safety.

## FUTURE DIRECTIONS

There is a necessity to address this clear patient safety imperative for our specialty. Gluteal fat grafting deaths are occurring across medical settings, from poorly regulated strip mall clinics to accredited surgical centers.

Our Societies will proactively investigate the safety and efficacy of various clinical approaches and will educate and train members on those approaches that are most likely to improve

the safety of our patients. We, along with key stakeholders, will sponsor additional research and/or collection of real-world evidence to validate clinical approaches scientifically. At the same time, we will endeavor to shape public policy and support state, federal and country-specific regulations until the safety outcomes of gluteal fat grafting are comparable to other elective aesthetic surgical procedures. We realize the importance of real-time data in these efforts and strongly encourage surgeons to enter their data in the GRAFT registry.

Given the international nature of ISAPS and the differing jurisdictions in which its members work, ISAPS will continue to review the international consensus and periodically update its position in this area as new information emerges.

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*President, American Society of Plastic Surgeons*

**Bernard T. Lee, MD, MBA, MPH**  
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- Accessed via the worldwide web August 3, 2022 at: [https://www.plasticsurgery.org/Documents/Health-Policy/Positions/ASPS-Statement\\_Concurrent-Surgery.pdf](https://www.plasticsurgery.org/Documents/Health-Policy/Positions/ASPS-Statement_Concurrent-Surgery.pdf)



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CEZAR BUZEA, MD - BELGIUM

# THE BIRTH OF ANDREAS VESALIUS, THE FOUNDING FATHER OF MODERN HUMAN ANATOMY

*“Nullius addictus iurare in verba magistri, – quo me cumque rapit tempestas, deferor hospes.”* – Horace, 19 BC, Epistle I, Book I, line 14.

(I am not bound to swear allegiance to any master; where the storm drives me I turn in for shelter).

This December we celebrate the 508-year anniversary of the birth of Andreas Vesalius, the founding father of modern human anatomy.

He was born in Brussels and medicine was a long-standing tradition in his family. His great-grandfather was a physician and professor of medicine; his grandfather was the personal physician of the Holy Roman Emperor, while his father was a pharmacist. Naturally, he was bound to carry on the tradition so he started his studies with the arts, according to the standards of the era, not far away from home, in Leuven. Five years later he moved to Paris changing his plans, determined to pursue a military career, but soon he developed an interest in anatomy, spending countless hours dissecting human bodies. The outbreak of war between France and the Holy Roman Empire forced him to return to Leuven where he completed his studies. On the very day of graduation, the University of Padua in Italy offered him the chair of surgery and anatomy which he accepted.

The 23-year-old professor thus started a journey that would revolutionize not only the knowledge of anatomy, but also the

teaching itself. Before Vesalius, medical teaching consisted mostly of reading the classical texts of Galen, Hippocrates, Avicenna, and Rhazes. The anatomical dissections were quite rare and done in a mostly formal fashion: the professor (lector) read the text out loud *ex cathedra*, away from the dissection table while a barber (sector) dissected the cadaver, and an assistant (ostensor) indicated the anatomical structures from the text. During his tenure, dissection became an integral part of the anatomy course, with Vesalius himself performing numerous dissections without any help, doing what had used to be the job of three men.

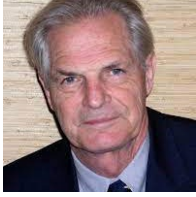
As a result, Vesalius came to realize that many of Galen’s teachings were false since they weren’t based on anatomical dissection. For instance, he discovered that the mandible consists of one bone and not two, and the sternum consists of three parts, and not seven as previously stated by Galen. He had contributions in all areas of anatomy putting together the experience of a lifetime in a monumental work, “*De Humani Corporis Fabrica Libri Septem*”, a seven-volume textbook of anatomy, packed with accurate illustrations. The first edition was published in 1543 in Basel, and was a huge success; it brought him European fame and the title of a royal physician. A second edition was published 12 years later in 1555. Today, around 700 copies from both editions survive, mostly in Europe.

So, this December, let us remember Andreas Vesalius.

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DENYS MONTANDON, MD - SWITZERLAND

# PART 1. SKIN EXPANSION AND ELONGATION SURGICAL USE OF PROGRESSIVE TISSUE EXPANSION AND ELONGATION SINCE ANTIQUITY



Figure 1: Elephantiasis (filariasis) of scrotum, penis, and lower limbs. Patient operated on by Dr. Brigitte Pittet in Benin.

As we all know, progressive tissue expansion is a natural phenomenon of the body during growth, obesity, and pregnancy. It is also observed in several pathologic conditions, the most impressive being lymphedema, Recklinghausen disease, and Marfan's disease. Lymphatic filariasis, commonly known as elephantiasis, may lead to almost infinite skin expansion, particularly if it affects the scrotum (Figure 1).

Artificial tissue expansion has also been a custom in several ethnic groups, as a tradition or to signify the appurtenance of a special caste. The insertion of a metallic ring of increased diameter into the lower lip was particularly common among Manguias women of Zambesia and other African ethnic groups and is still practiced today among Brazilian Indians, as is the case of Chief Raoni (Figure 2), who recently visited the United Nations in Geneva to protect his population and the Amazonian Forest. Earlobe elongation with heavy rings was also a common practice in the Vietnamese Djarais



Figure 2: Brazilian Indian Chief Raoni Metuktire with expanded lower lip.

and on Easter Island, where the population was once divided between two groups: the *long-ears* and the *short-ears*, the first being the dominant group. In some cases, the distended earlobes may have an enormous length so as to reach the clavicles. Pseudo-elongation of the neck, with multiple heavy rings added since childhood, is practiced among the Padaung or Kayan women in Myanmar. These heavy coils will eventually depress the clavicles and the first ribs at an angle of up to 45 degrees. Only a minimal increase in intervertebral discs has been noted on X-rays.

For the ancient Greeks, particularly the athletes who had to perform nude during the games, a long prepuce was a sign of respectability, and they took care to prevent unwanted exposure of the glans penis<sup>1</sup>. For the Greeks, the prepuce was composed of two distinct structures: the *posthe* and the *akroposthion*, distally. The consistent artistic portrayal in paintings of the adult penis with a generously proportioned *akroposthion* may well represent an anatomical ideal. It was considered by some to have a similar aesthetic and protective value, as the eyelid for the eye. In ancient texts, it is mentioned that many athletes applied a device called the *kynodesme* (literally a "dog leash") (Figure 3), a thin leather thong wound around the *akroposthion* that pulled

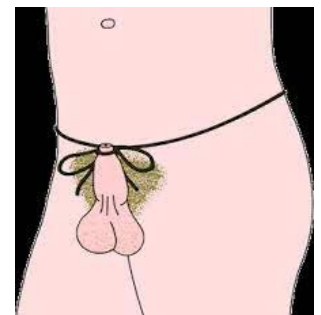


Figure 3: Ancient Greek athlete's kynodesme.



the prepuce and the penis upward and was tied in a bow, or around the waist. It is also known that the condition called lipodermic penis (lipodermos = lack of skin), or short foreskin, allowing the glans to be visible, was somehow humiliating and males affected by lipodermos, were seeking some type of correction.

### THE GAIN OF SKIN IN SURGICAL PRACTICE

The majority of reconstructive plastic surgery operations require the adjunction of well-vascularized skin and soft tissues. Various types of flap transfers have been used for centuries, but the possibility to gain skin by expansion is relatively new. Today, skin expansion with an inflatable balloon has become an indispensable tool for many kinds of plastic surgery procedures. In 1957 C.G. Neumann was the first to have the idea of using a subcutaneously placed rubber balloon to obtain expanded skin for the reconstruction of a partially avulsed ear<sup>2</sup>. This method was long forgotten until the 1976 ASPRS meeting, when the American-Yugoslavian plastic surgeon, **Chedomir Radovan** (1932-1984), presented his method of skin flap expansion with a silicon inflatable prosthesis<sup>3</sup>. Not very well received at the time, Radovan persisted with his idea, which caught the eye of Bill Grabb who proposed that this method would be one of the most important plastic surgery developments of our age. Radovan developed skin expansion mainly for breast reconstruction in collaboration with the Heyer-Schulte Company, producing the inflating prosthesis. According to Roger Khoury and his collaborators, breast enlargement could also be obtained using an external tissue expansion system.

In the head and neck region, after the first case report of Neumann in 1957, one had to wait for the publications of Radovan, before skin expansion became a frequent method for various procedures. All types and sizes of inflatable prosthesis are designed for indications such as scalp reconstruction, or as a preliminary maneuver for a forehead flap used in nasal reconstruction, allowing an easy closure of the forehead. Lip retractions after electric burns or other pathologies have been treated since the early 20th century with mechanical distractors to enlarge the commissures, however, it does not create new tissues. On the other hand, using a small inflatable prosthesis, we were able to expand a remaining lip stump with its vermillion border, to reconstruct an important lip defect in a case of noma<sup>4</sup>. Several other uses of expanding, and therefore

enhancing, the proliferation of skin and soft tissue have been described for better closure after the harvesting of flaps in the limbs and the thorax.

### SKIN ELONGATION

Considering only surgical skin expansion with an inflatable balloon might lead us to forget that other means of progressive enhancement of the skin surface and proliferation have been described in the past, and still have their indications today. Since the most ancient times, circumcision has been widely performed in most Egyptian, Arab, Phoenician, and Jewish boys, but during Greek and Roman Antiquity, it was considered as a mutilation and a severe aesthetic deformity, often leading to racial discrimination. As for today, a few circumcised men sought reconstruction of their foreskin for various reasons, mainly for better integration in certain societies, to avoid recognition of their religion or origin, or for physical and psychological reasons. One of the first mentions of actual uncircumcision can be traced back to the Old Testament (I Maccabees 1:14-15), "So they built a gymnasium in Jerusalem, according to Gentile custom, and removed the marks of circumcision, and abandoned the holy covenant. They joined with the Gentiles and sold themselves". This passage illustrates the dominant Hellenized culture of that age<sup>5</sup>.



Figure 4: The Ponderus Judaicus.

Several methods of foreskin reconstruction performed at that time have been reported, using a progressive stretch of the remaining foreskin. For this, surgeons used the so-called *Ponderus Judaicus* (Figure 4) made of leather, analog to the Greek *kynodesme*, and attached to the inner thigh. Other methods mentioned weight produced by the *krikos* for the Greeks or the *fibula* for the Romans, piercing rings made of bronze or copper, that could be fixed to the rudimentary preputial skin to pull it downward<sup>5</sup> (Figure 5). We are indebted to the Roman encyclopaedist **Aulus Cornelius Celsus** (c. 25 BC - c. 50 AD)



Figure 5: The krikos or fibula.





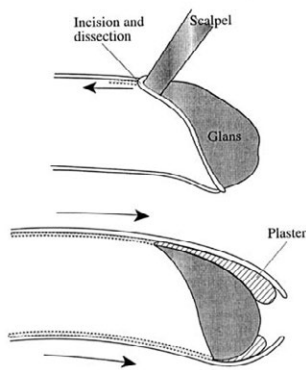


Figure 6: Celsus uncircumcision operation according to Rubin (1980).

for writing in detail, operations that were probably described and practiced by Greek surgeons in Alexandria<sup>6</sup>. In cases where conservative circumcision had been performed, leaving some of the inner layers of the prepuce intact, the skin was incised in a circular fashion, around the base of the penis, and mobilized distally, stretching over the glans. The neo-prepuce was ligated, leaving a small opening for urinating. In the second method, a subcoronary incision was made, and a full-thickness dissection was performed of the shaft. The elastic penile skin was pulled over the glans and ligated at the distally, and a non-adherent lead-oxide plaster was applied to prevent adhesion to the glans (Figure 6). Similar methods using progressive skin expansion for uncircumcision operations have been reported later during the Middle Ages by Oribasus (325–403 AD) and Paul of Aegina (625–690), and in the 19th century by the well-known German surgeon **Johann Friedrich Dieffenbach** (1792–1847). In his works, he compiled a chapter on what he called *posthioplasty* operation, also paying tribute to Celsus. Most of the modern methods of foreskin reconstruction are founded on these ancient operations, making use of skin stretching and expansion.

### SKIN EXTENSION BY GRADUAL EXCISIONS

In 1915, Hippolyte Morestin (1889–1919), the famous French surgeon of World War I, wrote an illustrated article entitled, “La réduction graduelle des déformités tégumentaires”<sup>7</sup> (The gradual reduction of tegument’s deformities), where he shows

in several examples how he was able to remove extended facial naevi with iterative simple operations, allowing the skin to expand progressively, “I have described earlier the method of spontaneous autoplasty by progressive stretching of the integuments ..., my present method is based on the same principle, it utilizes the nearly indefinite possibility of extension of the skin; it leads to spontaneous autoplasty, but by a quite different procedure” (Figure 7).

### CONCLUSION

For generations, mankind acknowledged the possibilities of tissue growth when submitted to progressive physical expansion, traction, or distraction. Except for the uncircumcision operations described by Celsus, and a few scattered reports, one had to wait until the end of the 20th century before surgeons could make real practical use of this natural phenomenon. Today, we know that putting skin under tension initially forces interstitial fluid out of the tissues and causes micro-fragmentation of the elastic fibers and changes in the alignment of collagen, allowing greater expansion of the skin, termed ‘creep’. Recruitment of adjacent mobile soft tissue also contributes to this initial phase of tissue expansion. A prolonged skin stretch induces an increase of the cellular mitotic rate, together with an increase of collagen content and ground substance dimension, which gives rise to true tissular growth, analogous to other regenerating mechanisms<sup>8</sup>.

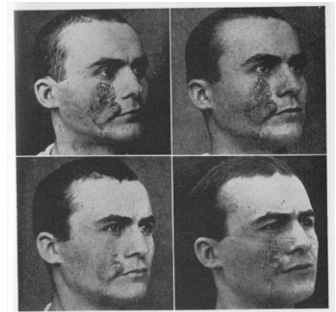


Figure 7: Skin expansion by gradual excisions (Morestin 1915).

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SERGIO CAPURRO, MD - ITALY

# SUBCUTANEOUS AND INTRADERMAL CELLULAR ADIPOFILLING OF THE FACE AND NECK: OUR TECHNIQUE OF PREPARATION, TRANSFER, AND PRESERVATION OF FAT

## INTRODUCTION

To reduce the size of the lipoaspirate, microcannulas, filters, centrifugation, etc. are used. These techniques are slow and damage the adipocytes, which are important to the success of volumetric and regenerative procedures. We designed and tested a technique called Adipofilling. This enables us to create a suspension of lobular fragments in a few seconds (**Figure 1**) and, in less than 30 seconds, to produce a suspension of living adipose and stromal cells (**Figure 2**).

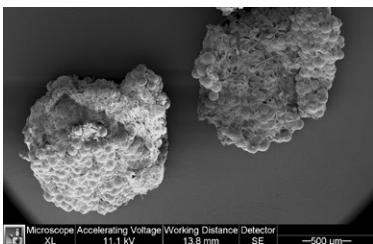


Figure 1: Scanning Electron Microscopy (SEM) lobular fragments, created by the suction vortex in six seconds.

The quality and quantity of these suspensions meet the needs of our aesthetic and reconstructive procedures.

## SURGICAL TECHNIQUE

The aspirated fat is separated by a suction vortex by an economical, disposable, battery-driven device (Adipopimer, Korpo SRL) (**Figure 3**).

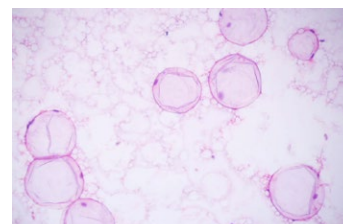


Figure 2: Smear of the cellular suspension created by the suction vortex in 30 seconds.

The particle size varies from small lobular fragments to single cells. These suspensions are used for subcutaneous volumetric enhancement and intradermal regeneration and will not freeze at storage temperatures (-30°C/-81°C).





Figure 3: The suction vortex of Adipopimer separates the aspirated fat into small lobular fragments or adipose and stromal cells.

**Local Anesthesia:**

The tumescent local anesthetic is a modified Klein solution of Mepivacaine.

**Liposuction:**

Liposuction is carried out through a 4 mm diameter cannula. Large-calibre cannulas with large holes minimize the damage to the cells that is caused by friction and maintain the integrity of the lobules.

**Washing Lipoaspirate in a Flask with a Tap:**

Washing must continue until the liquid becomes clear and transparent. This method of washing is economical and quick.

**Preparation for Lobular Fragmentation and Cell Separation:**

The lipoaspirate is poured into a beaker. A volume of lactate ringer or saline solution three times greater than that of the fat must also be poured into the beaker. For the suction vortex to work properly, the biological material must have enough space to separate without being damaged. The cathelicidin of adipocytes prevents any infection.



Figure 4: Subcutaneous Adipofilling of a rare bilateral facial atrophy. The result five years after completion of three Adipofilling sessions.



Figure 5: Upper lip wrinkles. Intradermal cellular Adipofilling. Stable result after one year.

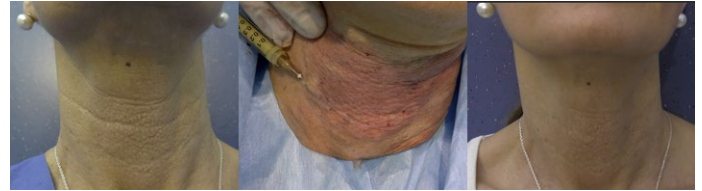


Figure 6: Neck wrinkles and skin elastosis. Intradermal cellular Adipofilling. Stable result.

**Separation of the Lipoaspirate with the Adipopimer:**

The Adipopimer is equipped with a stabilized ceramic (Y-TZP) blade of 1/3 mm thickness, which rotates at 133.3 revolutions per second.

**RESULTS**

The volumetric results of Adipofilling are clearly visible even after a single treatment (Figures 4-7). The cell suspension injected into the dermis rapidly regenerates aged and scarred skin.

**CONCLUSION**

Adipofilling enables defects, volume deficits, and aged skin of the face and neck to be efficaciously corrected. The procedure is rapid. When used in combination with other minimally invasive techniques (Elastic Lifting), it helps to achieve rejuvenation that meets biological criteria.

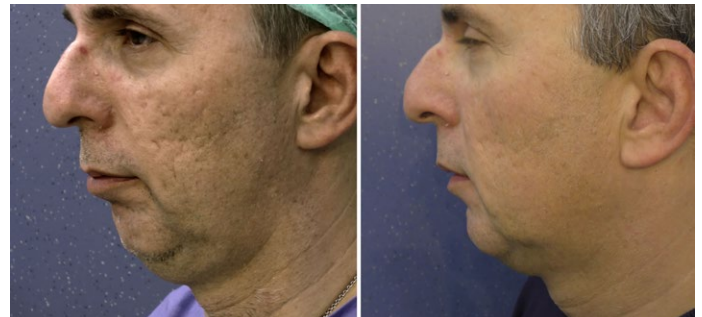


Figure 7: Outcome of facial acne scars. After a single session of subcutaneous and intradermal cellular Adipofilling.

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# FAT GRAFTING FOR FACIAL SCARS



ANEESH SURESH, MS - INDIA

Facial scars are a source of physical and psychological stress to the patient. Despite a plethora of options available for treating scars, fat grafting has gained tremendous popularity over the last decade owing to its minimally invasive nature, low procedural downtime, and excellent aesthetic outcomes.

Dr. Sydney Coleman standardised the *micro fat* grafting technique for lipofilling in 2001 and Dr. Patrick Tonnard et al produced *nano fat* by mechanical emulsification of *micro fat* and reported its lipomodelling properties in 2013<sup>1,2</sup>. *Micro fat* grafting and *nano fat* grafting, in combination, can be used to treat depressed and hypertrophic scars secondary to ageing, disease or trauma.

## SURGICAL TECHNIQUE

### Harvest:

Informed consent is obtained. Parts are prepared and draped. Lipoaspiration is done from the abdomen, or medial thigh, after infiltration with modified Hunstad's solution (800 mg lignocaine/litre and 1:1000000 adrenaline per 1000 mL of Ringer's lactate solution). I use a 2.4 mm cannula with sharp holes (1 mm) connected to a 50 mL Leur-Lok syringe for lipoaspiration. This method generates micro fat ready for lipofilling (*Figure 1*).

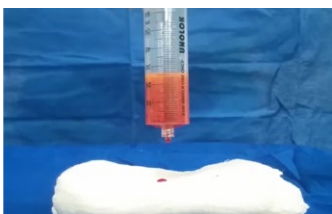


Figure 1: Micro fat after decantation.



Figure 2: Emulsification process.

### Preparation:

The micro fat is decanted until it separates into three layers. The upper and lower layers are discarded, and 1–5 mL of the middle fatty layer is transferred to a 5 mL Leur-Lok syringe for deep blunt-cannula (0.7 mm) injection and Sharp-Needle Intradermal Fat grafting (SNIF). The remaining middle layer (micro fat) is emulsified by passing into a similar empty 10 mL Leur-Lok through a 2.4 mm female-to-female Leur-Lok connector for 30 passes as recommended by Dr. Tonnard and Dr. Verpaele<sup>2</sup>. This is followed by 30 successive passes

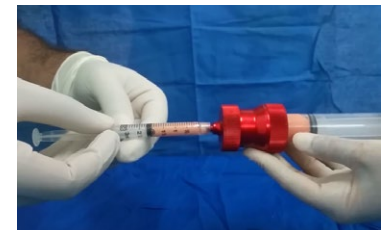


Figure 3: Nano fat.

through a 1.4 mm and a 1.2 mm female-to-female Leur-Lok connector (*Figure 2*). The emulsified micro fat is finally passed through a 400/600-micron filter to remove the fibrous elements (*Figure 3*). This nano fat preparation is then transferred to 1 or 3 mL Leur-Lok syringes for injection.

### Injection:

Under local anaesthesia (supraorbital/supratrochlear, infra-trochlear or mental nerve block using 2% lignocaine), the scar subcision is done using 18G needle (bevelled upwards). After subcision, *micro fat* is injected below the dermis using a blunt cannula (0.7 mm) for lipofilling. SNIF grafting is done with a 23G needle for deep intradermal injection, while the *nano fat* is injected into the superficial dermis and epidermis using a 27G needle for lipomodelling. The endpoint of injection is





the yellowish discolouration or blanching of the skin.

Depressed scars require subcision and injections at all three levels, whereas hypertrophic scars are managed by injections at two superficial levels (without subcision and blunt cannula injection).

**Safety Precautions:**

- Seven-minute wait time to ensure adequate action of the infiltration solution before lipoaspiration. This ensures good quality, blood-free micro fat harvest.
- A good local anaesthesia ensures a pain-free procedure.
- Subcision should be done meticulously to avoid skin puncture (which will lead to nano fat leak) and undue bleeding/bruising. This decreases post-procedure erythema and hyperpigmentation.
- The fat is injected while withdrawing the needle to prevent inadvertent intravascular injection.
- Because of the commonality of the Fitzpatrick 4-6 skin type in the Indian population, the chance of hyperpigmentation is high following the procedure. Hence, a strict post-procedure skin care regimen of sunscreen application, moisturizers, and topical Vitamin C is advised.



Figure 4: One-year follow-up in a depressed scar.

**CONCLUSION**

Fat grafting can achieve excellent aesthetic outcomes in all skin types with minimal complications. Injection of *micro fat* below the dermis elevates the depressed scar immediately, and a slight overcorrection is done to counter volume loss. However, the benefits of *nano fat* injection for scar modulation take at least a few months to appear and includes decreased pigmentation, scar softening and, improved skin texture (**Figures 4, 5, and 6**). The patient needs to be counselled regarding this delayed onset of improvement.



Figure 5: One-year follow-up in a mixed-type depressed and hypertrophic scar.

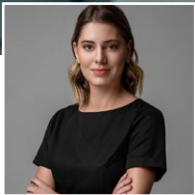


Figure 6: One-year follow-up in a depressed scar.

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# FACIAL FAT GRAFTING PROCESS: INFILTRATION SOLUTION, HARVESTING, INJECTION, AND SAFETY GUIDELINES

## INTRODUCTION

Facial fat grafting is a surgical rejuvenation procedure where liposuction is performed on a section of the body with available fatty tissue. The harvested fat is then processed and placed into small syringes for transfer into areas of the face that require volume repletion. In the last decade, fat grafting has attracted more and more attention from plastic and aesthetic surgeons. The fundamentals of modern technologies were developed at the end of the 80s by Professor Fournier<sup>1</sup>.

Autologous adipose tissue is considered by many to be an ideal filling material for facial rejuvenation, as it represents one of the most biocompatible dermal fillers with low allergenicity, produces a soft and natural result, and may have semi-permanent to permanent effects. This article focuses on the techniques and methods that we use in facial fat grafting.

## INDICATIONS FOR USE

- Wrinkles and folds;
- Congenital disorders of facial contours and body, or disorders caused by involuntal changes and ptosis of soft tissue;
- Post-traumatic and post-surgery scars, scar defects after acne;
- Unevenness in cellulite or after unsuccessful liposuction.

## OPERATION TECHNIQUES

### Anesthesia:

This is carried out by tissue infiltration with a solution of a local anesthetic without the content of components that act on the cell membrane of fat cells. The most accepted is the 0.1% solution of lidocaine. The volume of the injected solution, considering the specifics of a particular case, should



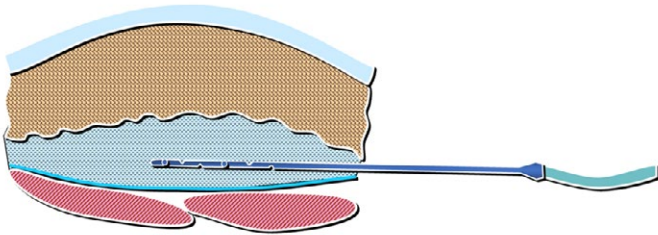


Figure 1: Infiltration process with a local anesthetic solution.

be 2-4 times more than during traditional liposuction. It is very important to note that the solution must be injected superficially, under the fat layer, from where the fat is supposed to be harvested (Figure 1).

With this procedure, not only is pain relief provided but also the fat is pushed closer to the skin, by compaction, which makes it easy to obtain a fatty “column” of the implant with the help of a Felman cannula containing minimally damaged adipocytes. Besides, in the operated area, blood vessels are compressed, and their lumen decreases, due to which bleeding practically doesn’t occur.

**Fat Harvest:**

Through a skin incision up to 5 mm in size, made in an inconspicuous place, through the reciprocating movements

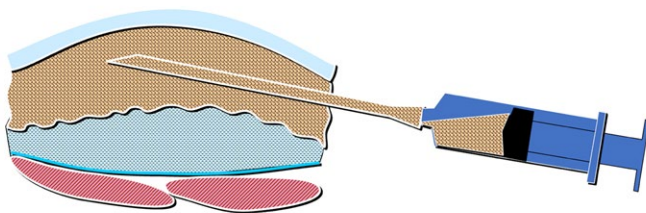


Figure 2: Material harvested with this method of anesthesia, is a solid fat implant without any admixture of the injected solution and blood, so it is immediately ready for transfer.

of the cannula, donor fat tissue is harvested into a 50 mL syringe attached to the cannula<sup>2</sup> (Figure 2).

**Injection:**

After harvesting, the resulting fat tissue is transferred into syringes with a volume of 2 mL (needles 27-30 G), with the help of the implant inserted into the marked zone.

**RESULTS**

To confirm the theoretical justification of the method, and positive long-term results of clinical experience, comparative morphological studies were undertaken. Anesthesia and fat implant sampling were performed on the same patient using traditional and new methods.

Since in the process of lipofilling, the fat implant must be squeezed out through the needle or cannula, which implies additional destruction of adipocytes, the fat implant, received through a new method, was squeezed out of the injection syringe 30 G and from the usually used Coleman cannula. Then both portions were subjected to morphological study.

An analysis of the data of morphological studies shows that the fragments of adipose tissue obtained through the Felman transparent cannula are larger than in other cases<sup>3</sup>. About 40% of the adipocytes contained in them retain their inherent structure and integrity, while in samples harvested through traditional technologies, only 15 to 30% are retained.

Thus, the conducted morphological studies confirm the best quality of the fat implant is obtained with the Felman cannula. Adipocytes of such implants have a higher chance of engraftment due to the absence of aggressive mechanical, toxic, and osmotic effects.

**REVIEW A SPECIFIC CASE**

The patient had an unsuccessful liposuction on the face area in another clinic, which led to complications including skin and soft tissue deformation, in particular local deformation



Figure 3: Unsuccessful liposuction on the face area.

of soft tissue of the right cheek. The patient was in this condition for four months and was undergoing conservative treatment such as a massage, but it had no result. The deformity was still showing. The goal of the operation was to fill the defect and even the cheek. As seen in the photograph, skin and subcutaneous tissues are fibrosically and tightly





Figure 4: Picture taken after 1 to 2 years.

interwoven with each other, and use of any dermal fillers will be unsuccessful (**Figure 3**).

Therefore, we performed an undermining of the defect, released the skin and subcutaneous tissues with a special wire scalpel<sup>4</sup>, and created a space where we can freely inject any filler. As a filler, we use the fat that we harvested using the Felman method (**Figure 4**).

## CONCLUSIONS

The proposed technique for collecting and preparing adipose tissue for auto lipofilling is safe, effective, and easy to perform by a surgeon. It differs favorably from the already known possible methods, with a significant increase in the number of viable transplanted fat cells, which contributes to the long-term clinical results. Another result was a significant reduction in the time of surgical intervention due to the absence of the need for centrifugation or any other processing of fat, reducing the cost of the operation due to the abandonment of expensive refrigeration units, centrifuges, cannulas, etc.

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# FACIAL FAT GRAFTING - MY WAY TO PREPARE THE FAT



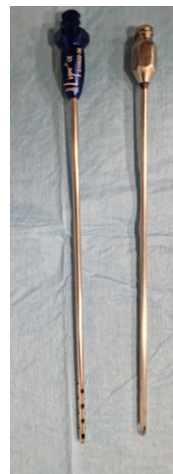
**JESÚS BENITO-RUIZ, MD, PHD - SPAIN**  
ISAPS National Secretary

Dr. Gustav Neuber is credited to be the first surgeon to transfer 1 cm fragments of adipose tissue from the arm to the face to treat scar defects in 1893. Later in 1910, Dr. Erich Lexer used fat for facial hemiatrophy and malar augmentation<sup>1</sup>. But we had to wait for Dr. Sydney Coleman, to standardize the atraumatic procedure that allows us to obtain good and reproducible results with the adipose tissue grafts and denominated Lipostructure™<sup>2</sup>.

Basically, it consists of an atraumatic fat collection (with 3 mm blunt cannulas and 10 mm syringes), centrifugation at 1286 g (3000 rpm with the Coleman Centrifuge) for three minutes to separate the adipose cells from the blood components and broken cells, which are then transferred to the tissue by blunt cannulas of about 2-3 mm in multiple passes, using 1 cc in each pass. In 1994, he described his fat injection technique for periorbital rejuvenation<sup>3</sup>. Micrografting became the key to success.

Despite the pioneering effort of Dr. Coleman and the enormous advances that his standardization of the method posed for fat grafting, one of the major criticisms and drawbacks of lipofilling, is the variable retention range reported. This unpredictability has led to the search for the best method of harvesting, which would ensure the best cellular viability and retention. Research has focused on the three phases of preparing the fat: harvesting, processing, and injection. However, there is insufficient scientific evidence to permit the standardization of procedures<sup>4</sup>.

The face has been one of the first targets for surgeons, not only for reconstructive but for aesthetic purposes as well.



*Figure 1: Luer-Lock Khouri (left) and Coleman (right) Harvesting Cannulae (3 mm).*

The description of fat compartments has allowed a better accuracy to augment specific sites of the face<sup>5</sup>.

For harvesting, the main conclusion is, that current literature suggests that there is no significant difference between different donor sources regarding cell viability or volume retention<sup>4</sup>. For the face, I usually harvest from the lower abdomen, flanks, or knee, depending on availability and the amount of fat that I need.

I use 10 cc Luer-Lock syringes with a Coleman Harvesting Cannula (3 mm), or a 3 mm Khouri Cannula with multiple holes sized 2 mm · 1.2 mm (Marina Medical, Stuart, FL), for small volumes (<50 cc) (**Figure 1**). A 10 cc syringe, after aspirating 2 cc of air (which is what Coleman recommended), results in a negative pressure of 0.37 at.6. In cases of facial lipodystrophy, or atrophy, and >50 cc of fat needed, I harvest with a 3 mm cannula connected to the liposuctor at 0.5 at. and I collect the fat in a redon bottle<sup>7</sup>.

I favor centrifugation for the preparation of fat for the face. I prefer this method for this indication because centrifugation produces concentration and “packing” of the cells, and I can determine more precisely how much volume I am grafting to each area. Dr. Masakazu Kurita et al.<sup>8</sup> compared the effect on cell viability of various forces of centrifugation (400, 800, 1200, 3000, and 4200 g) for three minutes. The greater the force of the centrifuge, the higher the oil and fluid fraction







Figure 2: Using 400 g for two minutes to separate the blood and oil components of the lipoaspirate.

production. Four hundred grams already produce the separation of the red fraction. The smaller the number “g”, the less damage to cells. Therefore, I use 400 g for two minutes to separate the blood and oil components of the lipoaspirate (Figure 2).

For mechanical dissociation of the fat, I use the Tulip NanoTransfer kit (Tulip Medical, Inc., San Diego, CA). The centrifuged fat is first passed through the 2.4 mm transfer to 3 cc Luer-Lock syringes. After this first pass, the fat is transferred to 1 cc Luer-Lock syringes. The deep compartments of the midface are passed through the 1.4 mm transfer, and the superficial compartments of the

face are passed through the 1.2 mm transfer (Figure 3). I use Coleman blunt cannulas for infiltration, 2 mm for deep injection (14 G or 16 G), and 1 mm (18 G) for the tear-through area, nasolabial, and marionette folds (Figure 4). For some deep rithyds, I fragment the fat with a few passes through the 1.2 mm transfer, and I inject it with a 21 G sharp needle. If fibrosis is present, a Toledo-V-shaped tip cannula is used.

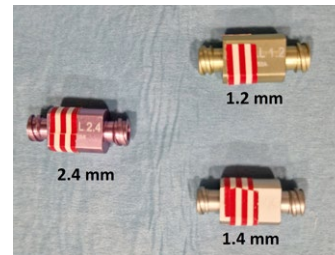


Figure 3: After an initial pass from 10 cc syringes to 1 cc syringe through a 2.4 mm transfer, a new transfer is done through 1.4 mm or 1.2 mm.



Figure 4: Coleman blunt cannulas for infiltration, 2 mm for deep injection (14 G or 16 G), and 1 mm (18 G) for the tear-through area, nasolabial, and marionette folds.

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# FACIAL FAT TRANSFER



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**GUILLERMINA MONTION - ARGENTINA**

Indications for facial fat transfer include aging, sun damage, and soft tissue deformities for cosmetic purposes.

It can also be used restoratively in congenital diseases and acquired soft tissue deformities, such as Parry-Romberg syndrome, Scleroderma, craniofacial microsomia, Treacher Collins syndrome, human immunodeficiency virus-related lipodystrophy, scarring, surgical defects, and trauma<sup>1</sup>.

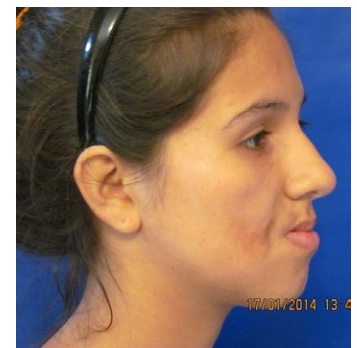
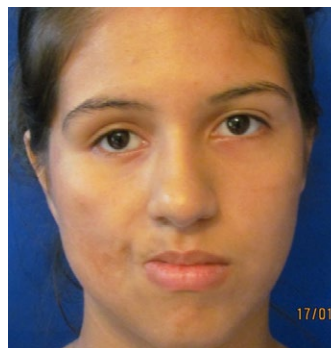


Figure 1: Fat decantation.

The collected adipose tissue (Figure 1), preferably from the periumbilical region, contains adipocytes and cells from the vascular fraction of the stroma. The stromal vascular fraction is composed of adipose stem cells, endothelial cells, vascular smooth muscle cells, and immune cells. Stem cells have been shown to modulate the immune system, support angiogenesis, degrade excess extracellular matrix, and undergo adipogenesis<sup>2</sup>.

Progressive hemifacial atrophy, also known as Parry-Romberg syndrome, is a disease that causes severe disfigurement and possible functional impairment. In these cases, fat transfer provides a treatment option, improving the quality of the skin and preserving the natural facial contours<sup>3</sup>.

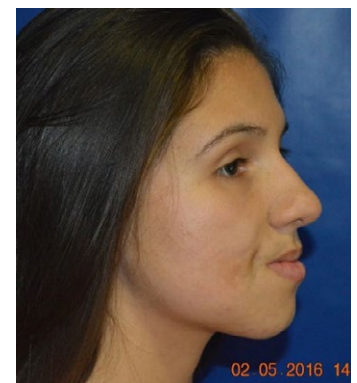
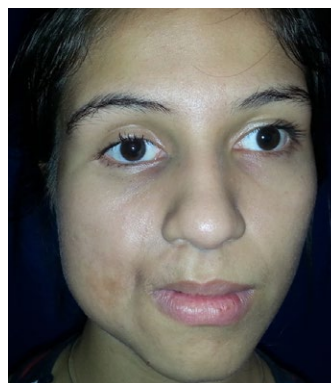
Scleroderma is an autoimmune disease characterized by inflammation that gradually progresses to fibrosis of the skin and internal organs. Lipotransfer provides growth factors and structural support, induces angiogenesis, and enhances enzymatic degradation of fibrotic tissue<sup>2</sup>.



Figures 2 and 3: Preoperative 15-year-old patient with Parry-Romberg syndrome.

## MATERIALS AND METHODS

The Facial Fat Grafting procedure is shared by the Parque de la Salud Plastic Surgery Service, Posadas Misiones Argentina in two patients, one diagnosed with Parry-Romberg syndrome (Figures 2-7), and the other with Scleroderma (Figures 8-11).



Figures 4 and 5: Same patient, three-year post-operative after two fat grafting sessions.

The selected donor site is the abdominal region, specifically the periumbilical region. Tumescence infiltration with a physiological



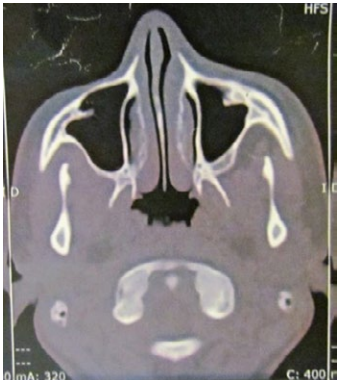


Figure 6: Preoperative image of the patient.



Figure 7: Three-year postoperative image of the patient.

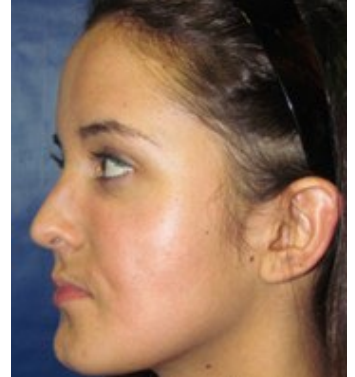
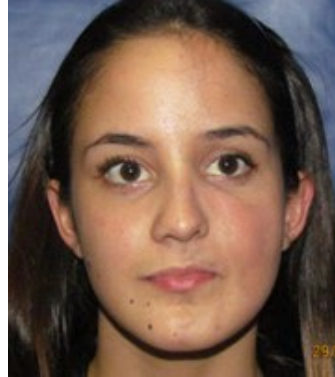
solution and epinephrine is performed, harvesting adipose tissue with a 3 mm cannula and a 20 mL syringe. Subsequently, sedimentation, tunnelization of the receptor site, and infiltration in the facial region with a 1.5 mm cannula and a 1 mL syringe were performed.



Figures 8 and 9: Preoperative 15-year-old patient with Scleroderma.

**CONCLUSION**

Facial Fat Grafting is an effective alternative for diseases or congenital malformations. Although it presents a variable degree of resorption, it not only provides volume but also produces skin improvement due to the cells found in the stromal vascular fraction.



Figures 10 and 11: Same patient, three-year post-operative after two fat grafting sessions.

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RICHARD WARREN, MD - CANADA

# FACIAL FAT GRAFT PREPARATION

Since the advent of injected fat grafting, a host of variables have been investigated including donor site, method of harvest, timing of fat grafting, method of graft insertion, and the topic of this discussion, the preparation of harvested fat.

Influenced by Dr. Sydney Coleman, I have been harvesting fat by suction and injecting it into the face for almost 20 years<sup>1,2</sup>. To process the fat, I have tried gravity separation, straining through gauze, and centrifugation. These personal evaluations, plus extensive literature on the subject, have demonstrated good results with all the popular methods, although enrichment with stromal vascular fraction has demonstrated somewhat improved results<sup>3,4</sup>. For practical reasons, my preferred processing technique in the breast and body is gravity separation and, in the face it is centrifugation. Therefore, in the face, I am using a modified version of the original Coleman technique without enrichment.

The typical scenario for facial fat grafting in my practice is the facelift patient, 90% of whom receive facial fat grafting at the start of the procedure.

Facelift patients are supine on the operating table, making the anterior surface of the body a practical donor site. The abdomen is prepared and draped, and a small puncture incision is made at a spot remote from the umbilicus (**Figure 1**). The umbilicus is avoided as an entry point for



*Figure 1: The abdomen is the most frequent donor site. A puncture is used remotely from the umbilicus.*

fat harvest because of the proven difficulty to adequately sterilize this area. If the abdomen is unsuitable, alternative sites are the thighs, the flanks, or the medial knees.

Local anesthetic containing epinephrine is injected into the donor site. The graft is harvested using a 12-hole 2.1 mm Tulip cannula attached to a 10 cc Luer Lock syringe with an internal clip holding the plunger to provide negative pressure (**Figure 2**).

When fat is to be injected around the orbit, such as in the upper lid sulcus, a smaller particle size is preferred; therefore, a fine fat harvester is



*Figure 2: A 12-hole 2.1 mm Tulip harvesting cannula is attached to a 10 cc Luer Lock syringe. An internal clip holds the plunger to provide negative pressure.*





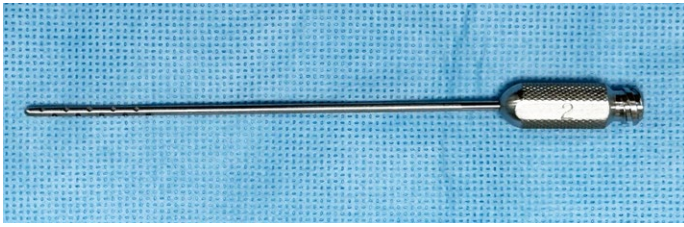


Figure 3: A fine particle harvester with aspiration holes measuring less than 1 mm in diameter.

used with the aspiration openings in the cannula measuring less than 1 mm (Figure 3). The harvested fat is handed off to nursing staff who place it in a centrifuge (Figure 4). The centrifuge is run at approximately 2,500 RPM for one minute. The purpose of the centrifuge is to separate the fat graft into three distinct layers: fluid and blood at the bottom, fat for injection in the middle, and oil at the top. By using centrifugation, the final product for injection is



Figure 4: The centrifuge used to centrifuge the donor fat for one minute.



Figure 5: The graft material after centrifugation, separated into three layers: water and blood at the bottom, fat in the middle, and oil at the top.

consistent from one syringe to another, and by keeping centrifugation time to a minimum, it is hoped that damage to the fat cells will be minimized (Figure 5).

After the syringes are removed from the centrifuge, the fluid/blood layer is drained from the bottom of the syringe, and oil is poured off from the top of the syringe, leaving fat for injection (Figures 6, 7). No special cleaning or treatment of the fat is done. Once separated, the fat is transferred into 1 cc syringes in preparation for injection (Figure 8).

The typical locations for fat injection during a facelift are over the malar prominence, the mid-facial groove, the deep medial fat compartment, the upper lid sulcus,

the tear trough, the pre-jowl sulcus, and the temples. The injection technique involves keeping the cannula moving and placing minuscule aliquots of fat using a spray gun technique.

For fat injection in the face and neck, the skin is punctured with an 18 G needle, and three different injection cannulas are used, depending on the location. The Coleman Mini II (20 G equivalent) is used for the precise injection of small



Figure 6: Draining of the fluid and blood from the bottom of the centrifuged syringe.

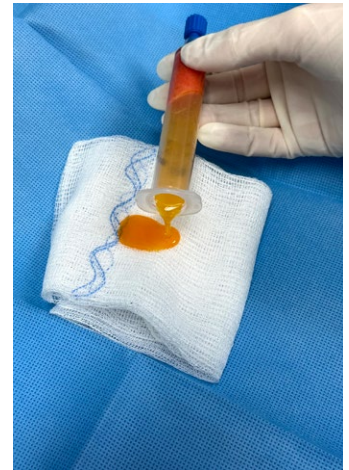


Figure 7: Pouring off the oil from the top of the centrifuged syringe.

aliquots, such as in the upper lid sulcus, the tear trough, or the deep medial fat compartment. The Tulip 0.9 mm (19 G equivalent) is used for larger deposits such as the mid-facial groove or to augment the mandible. The Tulip 2.1 mm (16 G equivalent) is used for deeper areas requiring larger volumes, such as the malar prominence and the temples. A sharp 18 G needle is used for the earlobes (Figure 9).

When there is finely wrinkled skin in the lower half of the neck, improvement can be difficult using standard face and neck lift surgery. For improvement in the skin quality in this area, I have found the addition of fat graft directly under the skin to be very helpful. Rather than adding volume, the concept is to create a thin carpet of fat immediately under the



Figure 8: Fat for injection is transferred through a Luer Lock connector to 1 cc syringes.



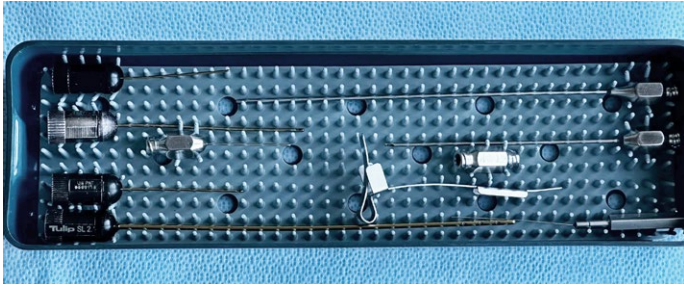


Figure 9: The entire fat injection and harvesting kit containing two harvesting cannulas, five injection cannulas, a holding clip for the 10 cc syringe, a Luer Lock connector, and a stilet for cannula cleaning.

lower neck skin, partly to replace fat lost through the aging process, and partly to provide a stem cell rejuvenation effect to the overlying skin<sup>4</sup>. To do this, the fat graft is mixed 50:50 with saline, and the diluted mixture is injected subcutaneously under the neck skin (**Figure 10**). Multiple passes are necessary to create a smooth layer of fat graft in the immediate subcutaneous plane.

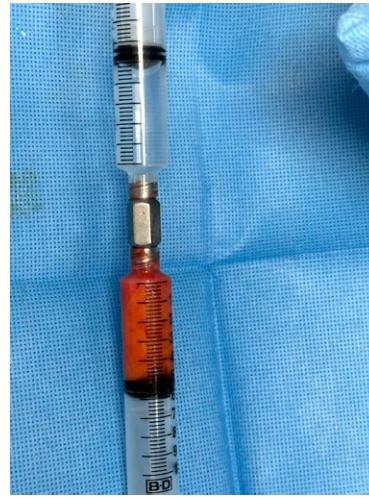


Figure 10: Mixing 5 cc saline and 5 cc of fat to create 10 cc of dilute fat for subcutaneous injection in the lower neck.

The addition of volume during facial rejuvenation surgery has been one of the major advances in facial rejuvenation surgery over the last three decades. While graft take is never 100%, in the less mobile portions of the face such as the malar prominence, the percentage take of fat graft can be very high, and once in place, it will be permanent.

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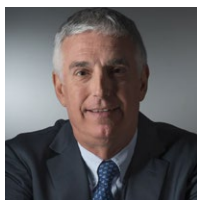
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PIERFRANCESCO CIRILLO, MD - ITALY

## COSMETIC SURGERY AND VAT: HISTORY OF PREJUDICE AND DISCRIMINATION

A strange storm is sweeping across Europe, but as is often the case, the winds change direction and power, country by country.

Italy is a paradoxical story, made of omissions rather than commissions, of legitimate questions asked and answers never received, of rubber walls difficult to scratch. It is a purely Italian story, made of public hypocrisies, and inexplicable private obtuseness.

Starting in 2016, the Italian Tax Agency has been demanding, moreover not uniformly across the Italian territory given the interpretative autonomy enjoyed by the peripheral offices, a VAT on aesthetic surgery procedures. This VAT is collected from plastic surgeons who have not paid this tax, retroactively for five years, with penalties and interest that more than double the amount demanded.

The problem is that all Italian plastic surgeons have NEVER applied VAT on their services, as it was the Tax Agency itself, in Circular No. 4/E of 2005, the Agency's only circular on this subject, which has never been revoked, that told them not to apply it, since these are medical services ontologically related to the psycho-physical well-being of individuals.

However, as mentioned, some peripheral offices, despite the aforementioned 2005 Circular which is supposed to bind their work hierarchically, interpreted a 2013 ruling of the Court of Justice of the European Union to mean that their services would instead be VAT taxable, and this despite the fact that this ruling refers to services rendered by a company (not by individuals directly authorized to perform such services), and concludes that the "therapeutic" purpose may well be integrated even by mere psychological problems, which therefore constitute sufficient reason for VAT exemption.





Take for example this situation: a plastic surgeon who suddenly receives a request from the Tax Agency for a sum of, for example, €30,000.00 in VAT, never claimed from patients and never collected, for the year 2018, plus penalties and interest, all amounting to €90,000.00! One has to wonder with what legitimacy this happens.

This in turn creates a new major problem, as there are now dozens of practitioners, some forced to close their practice, harassed by assessments and appeals concerning only the application of VAT, but they are exclusively plastic surgeons.

No Ear, Nose, and Throat (ENT) practitioner has ever been challenged about the nature of their surgeries with aesthetic purposes, no maxillofacial surgeon, and no dermatologist.

And if we want to make the matter even more clear, there are many specialties and treatments that, according to the Tax Agency's 'Taliban' interpretation, should have applied for VAT. For example, dentists, for dental veneers, dermatologists for baldness treatments, sports physicians for enhancing medicine, gynecologists for post-menopausal vaginal rejuvenation treatments, urologists for volumetric penile surgeries, ophthalmologists for lasers to eliminate eyeglasses, anesthesiologists participating in cosmetic surgery, etc.

More than a year after sending a Deed of Signification and legal advice, which could create a confrontational discussion by which a precise regulation would be arrived at for all, still a deafening silence from the headquarters of the Tax Agency.

Meanwhile, the assessments and files for our plastic surgery colleagues, which are exclusively for them, keep coming.

It should be made very clear that for us VAT is not a problem, but someone needs to establish, once and for all, whether there is a "non-therapeutic" medicine to which VAT should be attributed, and, if so decided, to put in black and white how, when, where and why to apply this tax, without any discrimination between medical specialties.

And above all, to apply it only for future procedures, and not make it retroactive, because it constitutes a general principle, repeatedly stated by the Court of Justice of the European Union, that in the presence of unambiguous indications coming from the tax authority in charge thereof to which the taxpayers have complied - and this is the precise case - no TAX, no SANCTION, and no INTEREST can be demanded, except from the moment when the NEW interpretative direction is formally externalized.

At this point, it is our right to have certain answers that will get us out of the precariousness to which this silence relegates us, and we ask for it within a certain timeframe. If we do not get an answer, in order to safeguard the decorum of our specialty, to protect all our specialist colleagues, and to inform our patients, we will take action with all the press capabilities, by any means, up to and including the purchase of pages of the most prominent newspapers, to publicize the affair under consideration and the consequences that this situation has on our category, and on the quality of our services.

We know very well who we are: we are plastic surgeons, some of us you see in the newspapers and on television, on social media we are rampant, sometimes with not too much good taste, but is that enough to justify such prejudice from a major public institution?

We are medical specialists, highly perfected with years of training and continuing education, and we can no longer stand idly in this situation, where our diagnostic and surgical services, are compared to waxing or beauty masks.

I think this is a battle that European countries and scientific societies in our field must fight together with conviction. The demand for clear, non-interpretatable, and shareable rules is a legitimate demand so that we can live our profession without precariousness, anxiety, or uncertainty.

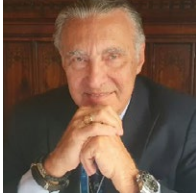
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# THE FUTURE OF PLASTIC SURGERY



LUIZ TOLEDO, MD - UNITED ARAB EMIRATES

## INTRODUCTION

I was recently asked to write a chapter for a plastic surgery book about the future of our profession. I have, throughout my career, always tried to position myself in the front line. I asked my social media plastic surgery groups and other colleagues for ideas to perhaps include in the article. Their reply was immediate. Everyone had something to say, and a few had already written about it. I decided to use some of their ideas in this article, and I mention them at the end.

In the late 1980s, I created a symposium called *Recent Advances in Plastic Surgery* (RAPS). The first three meetings took place in São Paulo, Brazil until 1992, and the following nine events were located in Belgrade, Serbia, until 2012. The meetings focused on new ideas and techniques from around the world.

In 2006, I was the guest editor of an issue of *Clinics in Plastic Surgery*, dedicated to lipoplasty and fat grafting, and we covered the subject thoroughly including, at the time, the new research on the role of adipose stem cells, considering all the future possibilities of the new technique. In 2009, I was again asked to guest edit an issue of *Clinics in Plastic Surgery* called, “*Emerging Techniques in Aesthetic Plastic Surgery*”, which addressed new solutions to old problems. There is always a fine line between the new and the experimental, and between the breaking news medical advances and quackery.

Futurology can be summarized with three Ps and a W, i.e., “possible, probable, and preferable” futures, plus “wildcards”, which are low-probability, high-impact events. A key part of future analysis is the managing of uncertainty and risk. We as professionals must adapt to the new times,

considering new social, cultural, and technological factors that influence the perception, expression, and desires of our patients.

Plastic surgery is changing at a faster rate, and it must adapt to the changes. Some new specialties will be incorporated, such as regenerative medicine, tissue engineering, etc. For example, the future of plastic surgery might be in tissue replacement. With adipose-derived stem cells, we are creating muscles, nerves, and bones.

**We can look at the future of plastic surgery from different perspectives:**

### 1. THE FUTURE OF SURGICAL TECHNIQUE

We must look at the techniques that are already here and being implemented. Modern plastic surgery is divided into two eras, before and after liposuction. In 1980, Dr. Yves Gérard Illouz, a “wildcard”, was responsible for disseminating a technique that allowed us to treat the body and face with minimal scars for aesthetic and reconstructive procedures.

In 1983, Drs. Illouz and Pierre Fournier started to inject aspirated fat, giving new life to the fat grafting technique that had been abandoned in the 1950s. It took about 40 years for fat grafting to be accepted as a serious way to improve depressed areas of the face and body. Now it is again in the frontier of science with the research concentrating on enhanced methods. Fat grafting into muscles is once again becoming a trend, combined with superficial liposuction, on what is now called 3D, or High-Resolution liposculpture. And now fat injection into the muscle can be guided by ultrasound to avoid injecting into blood vessels.



Simultaneous with fat removal and injection, one of the main concerns has been how to treat excess skin without unnecessary scars by creating retraction. We knew that skin could expand and retract when we looked at the ears and lips of Brazilian Indians, or by looking at an abdomen of a pregnant woman after delivery. But how to create a predictable and uniform skin retraction? When we started performing Superficial Liposculpture in 1989, we realized we could challenge the “Illouz ‘law of skin retraction’”, where instead of leaving a 1 cm layer of fat attached to the skin, we would leave only a 3-5 mm layer, thus improving retraction, and changing Illouz’s law. Many techniques and instruments are now specifically correlated with the role of skin retraction.

## 2. THE FUTURE OF INSTRUMENTS

We will discover new instruments and obtain new uses for old ones. Just in terms of liposuction alone, we saw many attempts of improvement to the aspirator, syringe liposculpture, the V-tip cannula to treat retractions, power-assisted aspirators, internal and external ultrasound devices, radiofrequency, and many others. With the advent of the use of lasers in the 1990s, we could resurface the skin or use laser liposuction. The principle was the same, we should “burn” the skin or dermis in a uniform manner to create retraction. Many other techniques, such as the use of ultrasound or radiofrequency waves, always with the same goal, controlled skin “burning” and retraction.

## 3. THE FUTURE OF NON-SURGICAL ADVANCES

Some doctors are concerned that we depend on a billionaire industry that, with constant offers of new products, seemingly becoming the trendsetter. Patients now come asking for a specific machine or product, and the product industry views us as puppets. They influence the aesthetic market, pushing their products. They are not concerned with who uses their products, and at times appear to have little concern with safety. The question remains: *who is going to control this progress and the limits of our specialty?*

In 1968, Dr. Christiaan Barnard (1922-2001), was a South African cardiac surgeon who performed the world’s first human-to-human heart transplant operation. After rheumatoid arthritis in his hands, he ended his surgical career, he and retired as Head of the Department of Cardiothoracic Surgery in Cape Town in 1983. He then became interested

in anti-aging research, and in 1986 his reputation suffered when he promoted Glycel, an expensive “anti-aging” skin cream.

Dr. Trudy Vogt was a plastic surgeon in Zurich, Switzerland. She was one of the first in to specialize in the field of plastic and aesthetic surgery opening her own clinic in 1973. In 2000, Dr. Vogt was climbing the ISAPS ladder to become the first female ISAPS President, when her surgical interests shifted to anti-aging hormones. Some say that this cost her the ISAPS presidency, which then went to the Turkish plastic surgeon Dr. Guler Gursu, known by her peers as Gigi. Be that as it may, the anti-aging industry worldwide is predicted to grow, between 2020 to and 2026, from 58 to 86 billion US dollars.

The new trend of biomodulators for anti-aging has invaded the internet with machines and products. Who could predict that the injection of a paralyzing drug, botulinum toxin, a protein, and neurotoxin produced by the bacterium *Clostridium botulinum*, would become the number one procedure for plastic surgeons? The global botulinum toxin market size was valued at 5.8 billion USD in 2021 and is expected to have an annual growth rate of 11.5% from 2022 to 2030. Second, in patient preferences is the injection of fillers. The global dermal fillers market is projected to grow from 5.31 billion USD in 2022, to 8.74 billion USD by 2029, at a 7.4% increase in the period from 2022 to 2029. Perhaps Drs. Barnard and Vogt were ahead of their time.

## 4. CYBORGS

A cyborg, a combination of *cybernetic* and an *organism*, is a being with both organic and biomechatronic body parts. Restorative technologies restore lost function, organs, and limbs. Replacement of a human tissue should not be confined to *just* human tissues: bionic prostheses could provide a better function. We can now replace a human leg that has been amputated because of injury or illness. The use of sensors in the artificial leg aids in walking by attempting to replicate the user’s natural gait, as it would be prior to amputation.

There will be a great development in 3D bioprinted organ scaffolds, starting with noses and ears.

## 5. ROBOTIC SURGERY

Robotic surgery, or robot-assisted surgery, allows a doctor to perform a complex procedure with more precision,



flexibility, and control than is possible with conventional techniques. It is usually associated with minimally invasive surgery, procedures performed through small incisions. It is also sometimes used in certain traditional open-surgical or microsurgical procedures. The most widely used clinical robotic surgical system includes a camera arm and mechanical arms with surgical instruments attached to them, to enhance precision, flexibility, and control during the operation. The surgeon controls the arms while seated at a computer console near the operating table. The console gives the surgeon a high-definition, magnified, 3D view of the surgical site. The surgeon leads other team members who assist during the operation. In time, this will be done without the presence of the surgeon in the operating room, not even in the same city or country. And, still, in a distant future, the robots will have no need for a surgeon. They are learning faster than we can.

## 6. SOCIAL MEDIA

The achievement of modern beauty standards is a requirement increasingly demanded, often immediately, and intensely influenced by social networks. Our work reflects the current changes in society from the medical, social, and human points of view, for this reason, our responsibility as specialists is also greater. Our procedures and surgeries must consider the needs and desires of our patients but must also be performed as safely as possible.

A continuous improvement of the scientific and academic points of view is a requirement to be able to permanently evaluate, and incorporate, new practical and theoretical knowledge and technologies. Also, the delivery of our knowledge to the new generations is no longer exclusive to those who work in their training at universities, but to all of us who communicate what we do every day.

Our role in education and teaching is to collaborate in guiding their learning from a solid foundation, not only technically, but also in the human and professional aspects. Academia, and its way of sharing paid knowledge, is falling behind free modern media networks.

## 7. REGULATION OF THE PROFESSION

Dr. Ivo Pitanguy, the most influential plastic surgeon of the 20th century, used to say that there is no separation between aesthetic and reconstructive plastic surgery. They are one specialty. If we look at plastic surgery from

this prism, we know we will be working in the profession forever. There will always be congenital defects, accidents, burns, and trauma that will need a plastic surgeon.

To become a plastic surgeon in most countries one is required, after the general surgery residency years, to undergo an additional few years of training in reconstructive surgery. Only after that, is it possible to train to be a safe aesthetic surgeon. When complications happen, the doctor will be prepared to act. However, one of the main complaints nowadays is the invasion of our specialty by doctors without the proper surgical training, dermatologists, gynecologists, and even dentists, wanting a piece of the aesthetic pie.

In 2017, I was on my second term as Scientific Director of the Emirates Plastic Surgery Society (EPSS) and was worried about the direction we were going in the country. I decided to present a series of lectures on the Future of Plastic Surgery in the United Arab Emirates (UAE) and try to find ways to improve our profession and protect it from external influences that threatened our lives, and that of our patients, in a world where medical tourism and the invasion of the specialty by other members of the medical community without proper training, is posing danger to our society. They use cheaper materials and equipment to keep costs down, creating unhealthy competition, where medical tourism patients would come to see them, not because they were better, but because they were cheaper. I thought in the UAE we already had enough plastic surgeons in 2017 to treat the whole country, three times more in proportion to the population, than compared to the United States or Brazil. In many countries, doctors still try to communicate with government agencies to improve collaboration.

The International Society of Aesthetic Plastic Surgery (ISAPS) has a mission:

- Organize and disseminate aesthetic education worldwide;
- Promote patient safety;
- Protect our high ethical standards;
- Publish high-quality research;
- Communicate our work broadly within and beyond our specialty.

ISAPS believes that if we follow these rules, our future should be bright.







*Illustration: Exo-skin project, by Dr. Amani Al Aidroos, at the Dubai Museum of the Future. Photo by Dr. Luiz Toledo.*

## CONCLUSION

If a surgical procedure can be replaced by a pill, who would opt for surgery? Radical hemithoracectomies disappeared from the treatment protocol for tuberculosis when Streptomycin was discovered. The same happened to gastrectomies for peptic ulcers and Omeprazole, or silicone implants for erectile dysfunction and Viagra. Some

surgical procedures will surely be replaced by non-invasive treatment modalities.

As plastic surgeons, we have been progressively transforming ourselves into educators, sociologists, and social communicators of a new reality. The personal satisfaction of what we are and what we do, is what will allow us to continue motivating us to develop our specialty in the modern world.

I would like to thank my following colleagues for their input: Drs. Montserrat Fontbona, Ashok Gupta, Ivar van Heijningen, Samir Ibrahim, Amin Kalaaji, Saeed Kaldari, Manoj Khanna, Zoltan Kruppa, Peter Neligan, Ernst Magnus Noah, and Bertha Torres Gómez.





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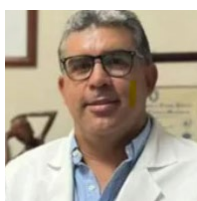
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# ISAPS TRAVEL



**DOUGLAS NARVAEZ RIERA, MD - VENEZUELA**  
ISAPS National Secretary

## WINE AND CHAMPAGNE IN THE TROPICS? VENEZUELA'S EXPERIENCE

Although wine was introduced in Venezuela by the Spanish during the late 15th and early 16th centuries, the first wine production actually started in 1920, in the center of the country, which was quickly replaced by the production of wine from imported concentrated must (from the Latin vinum mustum, "young wine")<sup>1</sup>. This type of initiative had its peak between 1958 and 1970, due to the economic policies implemented at the time.

A new stage in the production of wines in Venezuela started in 1983, when research and development agencies of Viticulture and Enology implemented national programs for the introduction of varieties of wine grapes. The first studies were carried out in areas of the arid states of Lara and Zulia.

Currently, there are two types of wineries: the first use **fresh grapes** for wine production and sangrias, and the other use

all or part of imported and **concentrated must** to produce wine and sangria.

There are two well-defined production zones: the first one is in Lara State which holds 95% of the production, and the second one is in Zulia State, with a total of 730 hectares of wine grape vineyards.

### **Zone of Lara State:**

#### 1. Production Area

Lara State covers 694 hectares of wine grape vineyards, of which 684 belong to the private enterprise Bodegas Pomar, and 10 belong to the Institute of Grapes, which is an organization of the Central-West University, "Lisandro Alvarado". The production is around 1,040,000 bottles of wine, with part of the grapes being used to produce sangria.





2. Varieties and Rootstocks

The red varieties for making wines in this area include Tempranillo, Syrah, and Petit Verdot, and the white varieties include Sauvignon, Chenin Blanc, Macabeau, Malvosie, Muscat Petit Grain, and Moscato Bianco.



Figure 1: Dr. Douglas Narvaez Riera and his wife.



Figure 2: Air balloon at Pomar's wine fields in Carora, Venezuela.

year, the first of these, is in the months of February through March, and the second one is during the month of August. The average length of cycles it is measured from pruning to harvest, ranging from 114 to 133 days, from the more precocious varieties such as "Tempranillo", to the less precocious "Petit Verdot". It has been observed that the "Tempranillo" variety cycle time can vary, starting at 95 days at an altitude of 30 meters, and up to 130 days at an altitude of 1,100' meters, as an effect of different temperatures.

Enthusiasm for wine consumption in Venezuela has grown to reach an impressive number of wine-lovers, even though other alcoholic beverages used to be more popular. One interesting point to highlight is the fact that champagne follows the "Methode Traditionelle" or "Champagne Method" which is carried out by an excelling technique that has allowed our winery, Pomar, to win world-tasting events for several years (Figures 2-4).

3. Production Periods and Production Cycles

These are based on the phenomenon of continuous growth that occurs in tropical conditions, adapted to periods of drought that occur in the area. There are two harvests per

I invite you to try one of our "tropically" produced wines and champagnes.



Figure 3: Pomar's winery in Carora, Venezuela.



Figure 4: Pomar wine from Carora, Venezuela.



Figure 5: Pomar wine selections from Carora, Venezuela.

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Dr. Gustavo Mantrana Sr.

**Vietnam**

Prof. Tung Dinh Nguyen  
Dr. Tu Dung Nguyen Phan Sr.



# MEETINGS CALENDAR



Master Class Webinar Series 2022  
Topics: Monthly topics in Aesthetic Plastic Surgery  
Link to register:  
[www.isaps.org/master-class-webinar-series-2022](http://www.isaps.org/master-class-webinar-series-2022)

## ISAPS APS JOURNAL CLUB: BODY CONTOUR UPDATE

Date: January 7, 2023  
Website: [www.isaps.org](http://www.isaps.org)

## ISAPS WEBINAR: GLOBAL ALLIANCE FOR WOMEN LEADERS IN AESTHETIC PLASTIC SURGERY

Date: January 7, 2023  
Website: [www.isaps.org](http://www.isaps.org)

## ISAPS OFFICIAL COURSE: INTERNATIONAL ISAPS FRESH CADAVER AESTHETIC SURGERY DISSECTION COURSE ON FACIAL PROCEDURES AND RHINOPLASTY

Dates: January 19-21, 2023  
Location: Liège, Belgium  
Venue: University Hospital of Liège  
Email: [info@isapscourse.be](mailto:info@isapscourse.be)  
Website: [www.isapscourse.be](http://www.isapscourse.be)  
Program: [View the program here](#)

## 3RD ANNUAL SESPRS/ISAPS FACIAL AND PERIORBITAL SYMPOSIUM

Date: January 26, 2023  
Location: Buckhead, GA, US  
Venue: The Intercontinental Hotel  
Email: [srussell@sesprs.org](mailto:srussell@sesprs.org)  
Tel: +1 435 901 2544  
Website: [www.sesprs.org](http://www.sesprs.org)  
Registration: [In Person](#) / [Streaming](#)

## ISAPS SYMPOSIUM - 57TH BAKER GORDON EDUCATIONAL SYMPOSIUM

Dates: February 9-11, 2023  
Location: Miami, FL, US  
Venue: Hyatt Regency Hotel  
Contact: Mary Felpeto  
Email: [www.bakergordonsymposium.com/contact](http://www.bakergordonsymposium.com/contact)  
Website: [www.bakergordonsymposium.com](http://www.bakergordonsymposium.com)

## AMERICAN-BRAZILIAN AESTHETIC MEETING

Dates: February 16-20, 2023  
Location: Sheraton Park City Utah  
Program: [2023-program.pdf](#)  
Contact Details: Grainne Gray  
Email: [ggray@sdeevents.com](mailto:ggray@sdeevents.com)  
Website: [www.americanbrazilianaestheticmeeting.com](http://www.americanbrazilianaestheticmeeting.com)

## ISAPS ENDORSED: VII HIGHLIGHTS OF PLASTIC SURGERY

Dates: March 1-4, 2023  
Location: Panama City, Panama  
Contact: Luis A. Picard-Ami Jr  
Email: [lpicardami@gmail.com](mailto:lpicardami@gmail.com)  
Website: [www.highlightsofplasticsurgery.com](http://www.highlightsofplasticsurgery.com)

## ISAPS SYMPOSIUM - AESURG 2023

Dates: March 1-5, 2023  
Location: Pune, India  
Venue: Aamby Valley City, Lonavala  
Email: [aesurg2023@gmail.com](mailto:aesurg2023@gmail.com) or [ashish@aestheticmedispa.in](mailto:ashish@aestheticmedispa.in)  
Tel: +91 99 2360 0302  
Website: [www.aesurg.in](http://www.aesurg.in)

## ISAPS OFFICIAL COURSE, SOUTH AFRICA

Dates: March 23-26, 2023  
Location: Cape Town, South Africa  
Venue: The Lord Charles Hotel, Somerset West  
Conference Organiser: Eastern Sun Events  
Email: [plastics@easternsun.co.za](mailto:plastics@easternsun.co.za)  
Website: [www.isapscoursesouthafrica.co.za](http://www.isapscoursesouthafrica.co.za)

## THE AESTHETIC MEETING 2023

Dates: April 19-23, 2023  
Location: Miami Beach, FL, US  
Venue: Miami Beach Convention Center  
Contact: Victoria Cierpich  
Email: [victoria@theaestheticsociety.org](mailto:victoria@theaestheticsociety.org)  
Website: [meetings.theaestheticsociety.org/the-aesthetic-meeting](http://meetings.theaestheticsociety.org/the-aesthetic-meeting)

## ISAPS APS JOURNAL CLUB

Date: May 6, 2023  
Website: [www.isaps.org](http://www.isaps.org)

## ISAPS APS JOURNAL CLUB

Date: July 1, 2023  
Website: [www.isaps.org](http://www.isaps.org)

## IMRHIS 2023 THE GLOBAL MASTERS RHINOPLASTY MEETING

Dates: June 29-July 2, 2023  
Location: Berlin, Germany  
Website: [www.globalrhinoplastymasters.com](http://www.globalrhinoplastymasters.com)

## ISAPS OLYMPIAD ATHENS WORLD CONGRESS 2023

Dates: August 31-September 2, 2023  
Location: Athens, Greece  
Email: [registrar@isaps.org](mailto:registrar@isaps.org)  
Website: [www.isapsathens2023.com](http://www.isapsathens2023.com)



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**ABSTRACT SUBMISSION IS OPEN**

**ABSTRACT SUBMISSION CLOSES:  
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