ISAPS® NEWS

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SOCIETY OF AESTHETIC PLASTIC SURGERY

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INSIDE

BOARD OF DIRECTORS

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MESSAGE FROM
the Editor-in-Chief

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

AESTHETIC PLASTIC SURGERY: A SPECIALTY WITHOUT LIMITS AND CONSTANTLY GROWING

It is impossible to separate aesthetics and reconstructive procedures – **this is the DNA of our specialty**. One of the characteristics of our specialty in aesthetic surgery is that we have the versatility of doing procedures on patients of all ages, both sexes, and on virtually any part of the body.

The origin of our specialty comes from the ancient Indian surgeon Sushruta (600 B.C.), where nasal reconstructions were carried out with cow leather, or pig leather in India. It was Gaspare Tagliacozzi (1545–1599) who, in 1590, taught us to perform nasal reconstructions with autologous tissue using an arm flap; obviously the background of all these reconstructions was for an aesthetic purpose. Impossible to separate from our minds is the name of Dr. Ralph Millar who, from the 1950s, shared the secrets of lip and palate malformation repairs, where it was clear that these reconstructions had both aesthetic and functional purposes. In current times, the manufacture of new generation breast implants and modern application techniques allow us to offer our patients high-security procedures for either aesthetic or reconstructive procedures. We must also mention a procedure that was initially developed to extract fat for aesthetic purposes (by Dr. Yves-Gerald Illouz, 1982) as the extracted fat is currently used in many reconstructive surgery processes as grafts. We now understand the great advantages and properties that this valuable tissue (fat) offers us as a biological stimulator for tissue growth.

Our specialty has grown exponentially over the years. Some time ago, it was unthinkable to imagine hair transplantations yet now, with modern hair transplant techniques, we can obtain surprisingly natural aesthetic results without virtually any surgical stigma. Our specialty allows multiple possible procedures to be performed on post-bariatric patients (e.g., massive weight loss), as well as aesthetic surgery in cases of gender reassignment and intimate area improvement in both men and women. We have also evolved in all high-definition techniques where we are now able to sculpt and change the shape of our patients' bodies by combining artistic extraction and fat injection. Our facial and neck rejuvenation procedures have been greatly improved by combining deep-tissue techniques with fat application to recover age-based atrophy areas. On the other hand, the positive impact on our daily practice, from all the injectable products and botulinic toxins that are now available on the market, is evident. We have multiple technologies capable of improving tissue quality or decreasing fat deposits, all in addition to treatments that improve cellulitis, a problem that presents in 85–90% of women over 35 years of age.

In Istanbul, Turkey, from September 20–24, 2022, ISAPS is committed to holding the most spectacular **Congress** in our Society's history. The program incorporates two days of non-surgical procedures for the first time, in addition to **keynote lectures** from experts at the ISAPS Business

School, three days of surgical procedures, and cadaver dissection workshops.

For these reasons, and more besides, we cannot miss this great world event. In addition to a scientific program of the highest world-class quality, the Congress organizers will offer unforgettable social events giving us the chance to reconnect with our colleagues and dear friends from different parts of the world. We will have the opportunity to enjoy a fascinating country – with its landscape, spectacular cuisine, and most certainly the kindness and hospitality of its people – and choose from a wealth of places to visit on both its Asian and European sides. This is our chance to learn about Turkey's history, greatness, and pride for what was once the Great Ottoman Empire.

Best wishes, strong hugs, and I hope to see you all soon.

Warmest regards,

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

MESSAGE FROM
the *ISAPS News* Co-Chair

FABIAN CORTIÑAS, MD – ARGENTINA
Co-Chair, *ISAPS News*

ISAPS® Global Leaders in Aesthetics

ISAPS GENOME

Dear Colleagues and Friends,

Our Society was founded more than 50 years ago at the United Nations by an enthusiastic group of **leaders**. Those plastic surgeons brought identity to **"aesthetics"** to such a degree that it became a separate discipline while, at the same time, many others were reluctant to accept this status.

Five decades after the foundation of ISAPS, **aesthetics** grew worldwide which shows the vision of our **Founding Leaders**. Furthermore, the Society also grew in all possible ways in consonance with that vision.

Is it possible that this attribute of **leadership lies within ISAPS' DNA?**

Indeed! Proof of this can be found in the Society's precise reaction to the COVID-19 pandemic: adapting resources and providing aesthetic education and relief in a brand-new scenario of unexpected lockdown and anguish, while also organizing one of the "first" post-lockdown World Congresses in Vienna, Austria, implementing electronic voting for election processes against the clock, and much more besides. ISAPS leadership DNA can be seen in many other achievements throughout the Society's young 50-year history but is also part of its members' genes.

ISAPS currently has 4,483 members in 115 countries all coming together with common goals: the passion for aesthetics, the pursuit of perfection, the feeling that we can learn from one another, and the awareness that we must therefore share what we have learnt.

Being a leader is not an easy task, even if in your genes, because it implies dedication and commitment. However, this is what we can currently see in evidence through the strong network we are creating among us and the social media response. ISAPS is becoming a point of reference for media channels and reporters, clear evidence of this being the increasing amount of queries received by our Executive Office. As the Communication Committee has a broad representation around the world, we are in an excellent position to provide specific information for each query regardless of its origin.

Our organization must keep growing as **global leaders in aesthetics**. Some may say we already are and, while this is true, being a leader requires continuous and consistent work to achieve and maintain this goal.

Hope you enjoy this first *ISAPS News* of the year – it is full of very interesting articles and expresses the diversity and richness of our genes.

Best regards,

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

MESSAGE FROM
the ISAPS President

Dear Friends,

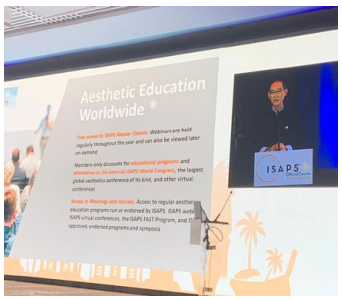
I am very grateful to the entire ISAPS Executive Office team, our Board of Directors, committees, and most of all our members for continuing to contribute so actively to our community and to our *ISAPS News*.

At this difficult time, as we continue to hear increasingly distressing news from Ukraine, it was important for me to read the article from Dr. Montandon in this issue. He reminds us of the value of our skills as plastic surgeons in humanitarian work and reflects on the foundations of the ICRC more than 150 years ago (this of course being one of the organizations now hard at work for Ukraine).

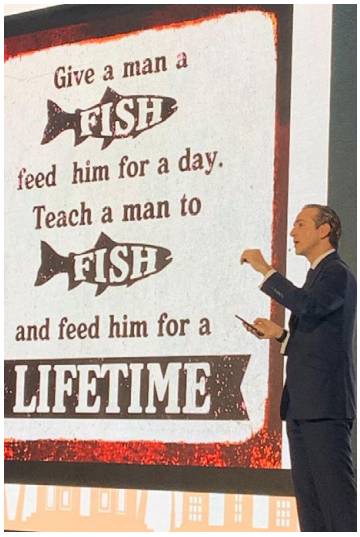
Our ISAPS Humanitarian Program Committee has been working hard over the last weeks, looking at how we may help our colleagues in Ukraine more practically, and we are grateful to those of you who have already reached out to offer to take part in a surgical mission should that become possible. In the meantime, we have launched a fundraising campaign to allow our ISAPS family to come together to show our direct support to the people of Ukraine. Thank you for your contributions.

Despite the challenges of the COVID-19 pandemic, our Society continues to bring the best in aesthetic education to its members and plastic surgeons all over the globe, with 22 ISAPS partner and endorsed events on the calendar ahead. In addition to maintaining our regular series of virtual webinars and live meetings from January 2022, our ISAPS Parliamentarian, Dr. Sanguan Kunaporn, is organizing the first ISAPS Course Thailand, from March 14 to 16, 2022 ***(Figures 1-7)***. For the first time ISAPS has streamed this official course, in order to allow more of our ISAPS family to access our education. You can still **sign up** to join the livestream or watch On Demand. I have a very busy meeting schedule over the next few months, presenting at ISAPS courses and ISAPS endorsed events in person. I will have the opportunity to meet many of you again at these meetings after such a long break, which I look forward to.

The Education Council, Executive Office team, and myself are working very hard on planning for the next ISAPS World Congress which, as your President, I am very excited to be hosting in my home city of Istanbul from **September 20-24, 2022**. Highlights for me include our first-time activities: a two-day non-surgical symposium; live surgeries course with cadaver dissections; a hair transplantation symposium, and a special pre-Congress sculpture course. Over 400 internationally renowned speakers have already accepted the invitation to participate, so I can promise you a very exciting program, and I hope to see as many members as possible back together again in person. Alongside this top-class scientific program, we are planning a lovely social program for you to enjoy beautiful Istanbul at night. I would like to encourage you to contribute to the program by **submitting your abstract** before **April 20, 2022 (6PM EST time)**.



Figures 1, 2, 3. The first ISAPS Course Thailand, Phuket, March 14-16, 2022.



Figures 4, 5, 6, 7. The first ISAPS Course Thailand, Phuket, March 14–16, 2022.

As membership is the most cost-effective way to register for our Congress, now is the time to renew your membership, if you have not already done so, or I invite you to join our Society as a **new member**. Please encourage your plastic surgeon colleagues and residents in plastic surgery training to join our wonderful **ISAPS family**.

Finally, I would like to take this opportunity to acknowledge all our ISAPS Active and Life members who took the time to vote on our Bylaws changes in January. We had a great voting turnout and are very pleased to confirm the approval of our new modernized Bylaws, which will equip us better for the future, enabling us to govern our Society in the most efficient way.

I hope you enjoy reading the first *ISAPS News* of the year. I thank its Editor-in-Chief, Arturo Ramírez-Montañana, Co-Chair Fabian Cortiñas, and our editorial team for their work in preparing this newsletter for us.

I send all of you my warm best wishes,

Nazim Cerkes, MD, PhD
ISAPS President, 2020–2022

MESSAGE FROM
the Education Council Chair

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

Dear ISAPS Members and Colleagues,

The ISAPS Education Council has had a busy start to 2022. On January 27, the 2nd Annual SESPRS/ISAPS Periorbital and Facial Symposium was organized in Atlanta. This was a live meeting, with good attendance, and it was encouraging to see our colleagues eager to participate in live events ***(Figure 1)***.

Figure 1. Faculty of 2nd Annual SESPRS/ISAPS Periorbital & Facial Symposium, January 27, 2022.

With our biennial ISAPS World Congress approaching, we have already sent invitations to the faculty and are happy to announce that over 400 prominent faculty have accepted our invitation. The 2022 World Congress in Istanbul, Turkey, is the most important aesthetic conference of the year, featuring live surgeries, hundreds of presentations, hot topic discussions, and many keynote speaker presentations. For the first time, the Congress incorporates a two-day non-surgical symposium which will be open to all plastic surgeons, our member affiliate practice staff, and dermatologist colleagues. Please share this news and encourage your colleagues to register to join us in Istanbul, September 23–24.

The Congress **abstract submission** is open, accepting abstracts until **April 20, 2022, 6PM EST time**.

Dr. Francisco Bravo and Dr. Sanguan Kunaporn have been working on organizing our first ISAPS Course Thailand, which takes place on the beautiful Island of Phuket from March 14 to 16, 2022. We have a great program and faculty, and the meeting also features live surgeries. The course will be livestreamed, enabling members further afield who are unable to attend in person to **register** and watch the event remotely.

Our webinars are also continuing, with our most recent Master Class on HD Body Contouring, held on February 26, 2022, still available to watch **On Demand**, in case you missed it.

If you are attending The Aesthetic Meeting in San Diego, don't miss our **ISAPS mini symposium** taking place on April 22, 2022. The symposium will feature great presenters, including Dr. Alfredo Hoyos, Dr. Ricardo Ventura Herrera, Dr. Stefan Danilla, Dr. Gerald O'Daniel, and Dr. Andre Auersvald.

Finally, ISAPS will be contributing to three of our Global Alliance Partner society meetings: **EASAPS** (European Association of Societies of Aesthetic Plastic Surgery), **TSAPS** (Taiwan Society of Aesthetic Plastic Surgery) and **KSAPS** (Korean Society for Aesthetic Plastic Surgery), all being held in April 2022.

Please mark your calendars for the ISAPS biennial World Congress – an event not to be missed. I am looking forward to seeing all of you in Istanbul!

Sincerely,

Ozan Sozer, MD

ISAPS GLOBAL ALLIANCE PARTICIPATING SOCIETIES

1. ALGERIA
Algerian College of Plastic and Aesthetic Surgery (CACPRE)
2. ARGENTINA
Sociedad Argentina de Cirugia Plastica Estetica y Reparadora (SACPER)
3. AUSTRALIA / NEW ZEALAND
Australasian Society of Aesthetic Plastic Surgeons (ASAPS)
4. AUSTRIA
Österreichische Gesellschaft für Plastische, Ästhetische und Rekonstruktive Chirurgie (ÖGPÄRC)
5. AZERBAIJAN
Society of Plastic Surgery Azerbaijan (SPSA)
6. BANGLADESH
Bangladesh Society of Aesthetic Plastic Surgeons (BSAPS)
7. BELGIUM
Royal Belgian Society for Plastic Surgery (RBSPS)
8. BOLIVIA
Sociedad Boliviana de Cirugia Plastica Estetica y Reparadora (SBCPER)
9. BRAZIL
Sociedade Brasileira de Cirurgia Plástica (SBCP)
10. BULGARIA
Bulgarian Association of Plastic, Reconstructive and Aesthetic Surgery (BULAPRAS)
11. CANADA
Canadian Society for Aesthetic Plastic Surgery (CSAPS)
12. CHILE
Sociedad Chilena de Cirugía Plástica, Reconstructiva y Estética (SCCPRE)
13. CHINA
Chinese Society of Plastic Surgery (CSPS)
14. COLOMBIA
Sociedad Colombiana de Cirugía Plástica, Estética y Reconstructiva (SCCP)
15. CYPRUS
Cyprus Society of Plastic, Reconstructive and Aesthetic Surgery (CySPRAS)
16. CZECH REPUBLIC
Czech Society of Aesthetic Surgery (CSAS)
17. CZECH REPUBLIC
Czech Society of Plastic Surgery (CSPS)
18. DENMARK
Dansk Selskab for Kosmetisk Plastikkirurgi (DSKP)
19. DOMINICAN REPUBLIC
Sociedad Dominicana de Cirugía Plastica Reconstructiva y Estética (SODOCIPRE)
20. EASAPS
European Association of Societies of Aesthetic Plastic Surgery (EASAPS)
21. ECUADOR
Sociedad Ecuadoriana de Cirugía Plástica, Reconstructiva y Estética (SECPRE)
22. EGYPT
Egyptian Society of Plastic and Reconstructive Surgeons (ESPRS)
23. ESAPS
European Society of Aesthetic Plastic Surgery (ESAPS)
24. ESPRAS
European Society of Plastic, Reconstructive and Aesthetic Surgery (ESPRAS)
25. FINLAND
Suomen Esteettiset Plastiikkakirurgit r.y. (SEP)
26. FRANCE
Société Française des Chirurgiens Esthétiques Plasticiens (SOFCEP)
27. GEORGIA
Georgian Society of Plastic Reconstructive and Aesthetic Surgery (GEOPRAS)
28. GERMANY
Deutsche Gesellschaft der Plastischen, Rekonstruktiven und Ästhetischen Chirurgen e.V. (DGPRÄC)
29. GERMANY
Vereinigung der Deutschen Ästhetisch-Plastischen Chirurgen (VDÄPC)
30. GREECE
Hellenic Society of Plastic, Reconstructive and Aesthetic Surgery (HESPRAS)
31. GUATEMALA
Asociación Guatemalteca de Cirugía Plástica Estética y Reconstructiva (AGCPER)
32. HUNGARY
Hungarian Society for Plastic, Reconstructive and Aesthetic Surgery (HSPRAS)
33. INDIA
Indian Association of Aesthetic Plastic Surgeons (IAAPS)
34. INDONESIA
Indonesian Association of Plastic Reconstructive and Aesthetic Surgeons (InaPRAS)
35. IRAN
Iranian Society of Plastic and Aesthetic Surgeons (ISPAS)
36. IRELAND
Irish Association of Plastic Surgeons (IAPS)
37. ISAPS
International Society of Aesthetic Plastic Surgery (ISAPS)
38. ITALY
Associazione Italiana di Chirurgia Plastica Estetica (AICPE)
39. ITALY
Società Italiana di Chirurgia Plastica Ricostruttiva ed Estetica (SICPRE)
40. JAPAN
Japan Society of Aesthetic Plastic Surgery (JSAPS)
41. JORDAN
Jordanian Society for Plastic and Reconstructive Surgeons (JSPRS)
42. KAZAKHSTAN
Kazakhstan Society of Aesthetic and Plastic Surgery (NSAPS)
43. KOREA
Korean Society for Aesthetic Plastic Surgery (KSAPS)
44. KUWAIT
Kuwait Society of Plastic Surgeons (KSPS)
45. LATVIA
Latvian Association of Plastic Surgeons
46. LEBANON
Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery (LSPRAS)
47. MACEDONIA
Macedonian Association of Plastic, Reconstructive and Aesthetic Surgeons (MAPRAS)
48. MALAYSIA
Malaysian Association of Plastic, Aesthetic and Craniomaxillofacial Surgeons (MAPACS)
49. MEXICO
Asociación Mexicana de Cirugía Plástica Estética y Reconstructiva (AMCPER)
50. MOROCCO
Société Marocaine des Chirurgiens Esthétiques Plasticiens (SOMCEP)
51. NETHERLANDS
Nederlandse Vereniging voor Esthetische Plastische Chirurgie (NVEPC)
52. NICARAGUA
Asociación Nicaragüense de Cirugía Plastica (ANCP)
53. NORWAY
Norwegian Society of Aesthetic Plastic Surgery (NSAP)
54. OMAN
Omani Society of Plastic, Reconstructive and Aesthetic Surgery (OSPRAS)
55. OSAPS
Oriental Society of Aesthetic Plastic Surgery (OSAPS)
56. PAKISTAN
Pakistan Association of Plastic Surgeons (PAPS)
57. PANAMA
Asociacion Panameña de Cirugia Plastica, Estetica y Reconstructiva (APCPER)
58. PERU
Sociedad Peruana de Cirugía Plástica (SPCP)
59. PHILIPPINES
Philippine Association of Plastic, Reconstructive and Aesthetic Surgeons (PAPRAS)
60. POLAND
Polish Society of Plastic, Reconstructive and Aesthetic Surgery (PSPRAS)
61. PORTUGAL
Sociedade Portuguesa de Cirurgia Plástica Reconstrutiva e Estética (SPCPRE)
62. QATAR
Qatar Society of Plastic Surgery
63. ROMANIA
Romanian Aesthetic Surgery Society (RASS)
64. RUSSIA
Northeastern Society of Plastic and Reconstructive Surgeons (NESPRS)
65. RUSSIA
Russian Society of Plastic, Reconstructive and Aesthetic Surgery (RSPRAS)
66. SAUDI ARABIA
Saudi Plastic Surgery Care Society (SPSCS)
67. SERBIA
Serbian Society of Aesthetic Plastic Surgeons (SRBSAPS)
68. SERBIA
Serbian Society of Plastic, Reconstructive, and Aesthetic Surgery (SRBPRAS)
69. SINGAPORE
Singapore Association of Plastic Surgeons (SAPS)
70. SOUTH AFRICA
Association of Plastic, Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA)
71. SPAIN
Asociación Española de Cirugía Estética Plástica (AECEP)
72. SPAIN
Sociedad Española de Cirugía Plástica Reparadora y Estética (SECPRE)
73. SWEDEN
Svensk Förening för Estetisk Plastikkirurgi (SFEP)
74. SWITZERLAND
Schweizerische Gesellschaft für Aesthetische Chirurgie (SGAC)
75. SWITZERLAND
Swiss Society of Plastic, Reconstructive and Aesthetic Surgery (SSPRAS)
76. TAIWAN
Taiwan Society of Aesthetic Plastic Surgery (TSAPS)
77. TAIWAN
Taiwan Society of Plastic Surgery (TSPS)
78. THAILAND
Society of Aesthetic Plastic Surgeons of Thailand (THSAPS)
79. TURKEY
Turkish Society of Aesthetic Plastic Surgery (TSAPS)
80. UKRAINE
Ukrainian Association of Plastic, Reconstructive and Aesthetic Surgeons (UAPRAS)
81. UKRAINE
Ukrainian Society of Aesthetic Plastic Surgeons (USAPS)
82. UNITED ARAB EMIRATES
Emirates Plastic Surgery Society (EPSS)
83. UNITED KINGDOM
British Association of Aesthetic Plastic Surgeons (BAAPS)
84. UNITED KINGDOM
United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)
85. UNITED STATES
American Society for Aesthetic Plastic Surgery, Inc. (ASAPS)
86. VENEZUELA
Sociedad Venezolana de Cirugía Plástica, Reconstructiva, Estética y Maxilofacial (SVCPREM)
87. VIETNAM
Vietnamese Society of Aesthetic and Plastic Surgery (VSAPS)

COMMITTEE REPORT

ISAPS Governance Committee

IVAR VAN HEIJNINGEN, MD – BELGIUM
Chair, ISAPS Governance Committee

GOVERNANCE: IT'S ALL ABOUT CULTURE, INTEGRITY, AND ETHICS!

Having seen my previous reports, you now know what governance is, and that its most important aspect is to follow ISAPS' purpose and strategy which our Board of Directors (BoD), who represent all our members, tries its utmost to do.

POSITIVE ORGANIZATIONAL CULTURE

Culture, integrity, and ethics describe the ideal mindset of a Board, but also an organization and its individual members. I always appreciate the friendship and openness of our Society, for example, any junior can reach out to a well-known senior member and most likely receive helpful advice and support. A positive educational culture and commitment to improve our patients' lives, in the safest and best way possible, is what we are about, and must be reflected in the BoD and committees that help to reach ISAPS' purpose of being "**Global Leaders in Aesthetics**."

INTEGRITY

We must set an example to the rest of the organization – especially in leading functions – with transparency and integrity, keeping our word when working together, and even more so when holding positions of responsibility within the Society. The more we all embrace this mentality, the better we become at reaching our goals.

So, what can you do to improve in this? Most importantly, be aware of your **role** and **responsibility** within the organization! Disclose other interests you may have, to avoid them becoming **conflicts of interest**. Many of us have roles in other societies and companies; there is nothing wrong with that if you do not misuse your position for your own benefit. From a governance point of view, having the right mentality is essential – of working towards a goal bigger than ourselves for the good of the society.

ETHICS

We hold a profession that is on the edge between medicine and commerce. We all think of ourselves primarily as doctors, but the perception of the media in general is often against us, seeing our specialty as commercial. Whether we agree or disagree with this is irrelevant as it is simply the reality. What we can do, however, is use that perception to drive us towards making good ethical decisions in every situation, always putting patient safety before profit. As plastic surgeons, we as individuals are scrutinized but also our medical practices, so always acting ethically is paramount.

DIFFERENT CULTURES

Culture is a mix of integrity and ethics, which also relates to how and where an individual is raised and trained. Erin Meyer, who wrote the book *The Culture Map*, describes the differences across cultures on communication, performance evaluation, persuasion, leadership, hierarchy, decision-making, trust, disagreements, and time perception. In

international societies, awareness of differences is essential to foster collaborative relationships and work towards the organization's common goal. Besides cultural differences, we have diverse personality types which can profoundly impact the dynamics within the BoD or committee. This realization helps us understand how relationships with the Executive Director and management team can influence the Society's effectiveness and outcome.

CONCLUSION

We swore, as physicians, to uphold the Hippocratic oath regarding our patients and, embedded in that oath is ethics, integrity, and culture. Well, governance is to any organization what the oath is to doctors, so we **must** embrace it!

Now that our new Bylaws have been accepted with an enormous majority vote, I will be touching upon these in the next issue, together with all the upcoming work on ISAPS' policies and terms of reference.

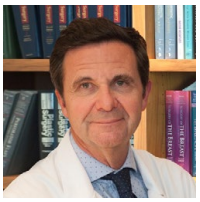
Sincerely,

Ivar van Heijningen, MD

ISAPS®
Global Leaders
in Aesthetics

7TH ISAPS AESTHETIC SURGERY DISSECTION COURSE 2022: AGAINST ALL VIRUS ODDS – LIÈGE, BELGIUM

IVAR VAN HEIJNINGEN, MD – BELGIUM
Course Director



JEAN LUC NIZET, MD – BELGIUM
Course Director

The 2022 dissection course in Liège was a roller coaster. In mid-December 2021 we hesitantly considered canceling the event but, with COVID-19 numbers decreasing, decided to go ahead. In January 2022, Omikron hit Europe and numbers skyrocketed. Three regular course instructors (Dr. Vakis Kontoes, Prof. Serge de Fontaine, and Dr. Gianluca Campiglio) canceled, due to travel restrictions, and the weekend before starting Dr. Alex Verpaele tested positive for COVID-19 ***(Figure 1)***.

Figure 1. Course Instructors and faculty.

Surprisingly, we had very few attendee cancelations with spaces filled from the waiting list. We asked our Belgian Assistant National Secretary, Dr. Peter MYNY, to step in but he fell ill and tested positive on the morning of the course!

So, with reduced instructors, we nevertheless started the 7th ISAPS Fresh Cadaver Aesthetic Surgery Dissection Course in Liège, Belgium, on January 20–22, with 32 onsite participants from 14 countries, four of whom were residents. This year, the far majority were from Europe (28) with four from the Middle East. Four participants were already ISAPS members, 23 came for the nose and face course, and nine for the face course only ***(Figure 2)***.

We duplicated the 2020 course set-up but focused more on teaching actual procedures. Participants learnt how to do an open rhinoplasty procedure on **day one**, following a very precise roadmap prepared by those instructors with a particular interest in this (namely Dr. Pascal Castus, Dr. Bahram Dezfoulian, Dr. Olivier Gerbault, and Dr. de Fontaine). Dr. Peter Palhazi gave an excellent presentation on anatomy of the nose, specifically focusing on the pitfalls of the procedures taught.

"Super dedicated and enthusiastic faculty..."

One instructor per two tables gave small hands-on presentations for the rest of the day. All attendees stayed focused to get the most out of the course, even during

Figure 2. Preparatory instructions.

coffee breaks. Our guest faculty, Prof. Birgit Stark, took time to demonstrate the dissection of the facial nerves, with all its branches, on a separate specimen. The participants rested after a tiring day, while the faculty shared an excellent meal in one of University of Liège's historic buildings.

Figure 3. Complimentary course dinner for all attendees.

Days two and three focused on face and neck procedures, starting with another great anatomy presentation by Dr. Palhazi. Combining course instructors, faculty, and course directors, we just had enough instructors to cover all tables. Friday focused on non-surgical, brow, and eyelid procedures: Viterbo's gliding brow-pexy, temporal lift, direct brow excision, upper blepharoplasty, single suture traction technique, and lower blepharoplasties, closing the day with Prof. Stark's presentation on "Zones of Awareness in Facial and Neck Rejuvenation". Attendees and faculty enjoyed great food and company at Friday evening's complimentary dinner, held at the Selys Hotel ***(Figure 3)***. The relaxed atmosphere helped everyone get to know each other and enjoy our evening together.

Saturday saw Dr. Daniel Labbé present "From Anatomy to Operating Room" on neck rejuvenation, then we focused on facelift techniques in the dissection room, starting with MACS-lift, the sub Smas techniques and the Auervald Net. The afternoon was given to neck procedures: midline platysmaplasty, lateral fixation, and platysma transection, ending with local anesthesia techniques and lipofilling, and Q&As.

"Fantastic course. Knowledgeable faculty. I like the time given for dissection...."; "I love the course, I will be back!"

The participants rated the overall course value very highly, especially the cadaver lab, while communication, registration, website, and event facilities were all well appreciated. Faculty and course instructors were rated "very good". As instructors, we appreciated the attendees' dedication to learning, and motivation; such a group were a pleasure to teach. A special thanks to our faculty and instructors who traveled from abroad and, to the Belgian faculty, we are very grateful to be able to count on you every year ***(Figures 4, 5)***. We hope to see you all next year for the 8th course in Liège, planned for January 19-21, 2023.

Figures 4, 5. Instructors, faculty and attendees.

THINK LIKE A BRAND

JUAN E. SIERRA MEJIA, MD – COLOMBIA
ISAPS Assistant National Secretary

Whenever we make a decision and project ourselves into the future, we should do it in a programed way, planning strategically. We should first think about our goal – the end of the road – and then define the steps to achieve this. We need to be clear on what we have to do, be aware of what we may lack to accomplish this, i.e., our weaknesses, but also identify our greatest strengths, always keeping the end-result at the forefront of our mind.

Think of your personal and professional life as a **company**, as this will allow you to take into account most of the variables involved in the process to achieve results in your career. The first step is to be clear about the objective and consider whether it really motivates you – does it make you wake up every day with high energy and purpose? Can it become the engine of your actions?

Every step of the way, verify the **principles** that will govern your decisions, the foundation on which you will build your dream – the golden rules that will guide you from the beginning to the end-result – so that anyone joining you in this process will understand and share these principles and make their own decision to follow your direction. Give yourself the necessary time to complete this exercise, so that you can then begin building your **personal brand**.

"Personal brand" is what people remember about you. If you build your brand in a coherent and orderly way, oriented and based on personal and professional goals, it will enable you to maximize your efficiency in both areas of your life. Everything will have a purpose, everything will have a meaning, and your defined principles will guide you towards success.

Understanding what personal brand means, and working on building yours, can be the greatest asset of your life. The first step is one of self-exploration, to investigate and look within yourself. Ask people close to you, *"How do you see me?"* – what qualities they extol but also what defects they see in you. Write everything down, analyze it, and see which words/phrases bring you closer to your self-image. Then, evaluate whether this image leads you closer to your dream or in fact hinders you. We should all be aware of our personal brand as, to know it is to know ourselves. Review how you would like to be perceived and what you want to achieve as this careful and thorough analysis will enable you to know your direction.

For example, do you want to convey **your expertise in mammoplasty?**

- First, focus on how you can help others and what their needs are, keeping this at the forefront of your mind.
- Then, refer to your breast surgery experience – how you deal with breast pathology and surgery prevention. Identify what is important to potential patients – their tastes, fears, etc. Talk about the topic at congresses and write about this area of surgery, so that patients and colleagues can appreciate what you do and most importantly, what you are.

Now that you have the steps to start, with the help of social networks and other forms of communication, you can put yourself forward as a reference for a topic, regardless of whether you have already graduated, or are in the formative years. This will make you an authority, enabling you to attract attention towards your knowledge and achieve consistent results for a successful career.

I hope you have grasped how to start creating a brand around your name, now you are starting to take the first steps towards a successful career. I recommend that you delve into the topic of **personal branding**, and I assure you that you will have the success you want.

ISAPS JOURNAL

MESSAGE FROM THE EDITOR-IN-CHIEF

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

Dear ISAPS Members,

We have had several major activities recently to further improve the Journal. First, we held a Strategic Planning Committee meeting in December 2021 to analyze where we are, where we want to be, and what we need to do to get there. In preparation for the meeting, and to clearly understand where we currently are, we first surveyed the Editorial Board members, asked many questions ranging from the appearance of the Journal to scientific content, improvement needed in the Editor-in-Chief's function, review process, editorial office function, and more besides. We carefully analyzed the suggestions and constructive criticisms, and the survey results were then used as the foundation of understanding "where we are" and "where we want to be." We then discussed, in depth, the steps needed to achieve "getting there". We made many decisions to address the concerns raised, and to guide us to reach our goals.

These included:

- Dr. Kai O. Kaye, MD, PhD
- Dr. Brian Peterson, MD
- Dr. Ewa A. Siolo, MD (ISAPS National Secretary)
- Dr. Chris Snijman, MBBCh
- Dr. Luciano Lanfranchi
- Dr. Sam Most

I take this opportunity to extend my welcome to our new Editorial Board members and let them know that I am very much looking forward to working with them in getting the Journal to the next phase.

I would also like to announce the establishment of **three awards** which will be offered to the **best article**, based on the number of downloads during the previous year, **most cited article**, and the **best resident article**, again, based on the number of downloads of articles when the resident is the lead author. The resident will receive $1,000 for this third award. All three awards will be announced and will be eligible for presentation during the ISAPS World Congress.

The survey results, and the outcome of the Strategic Planning Committee meeting, were then discussed at length during the Editorial Board meeting. A byproduct of the survey was the nomination of new Editorial Board members which was approved by the current members.

Sincerely,

Bahman Guyuron, MD, FACS

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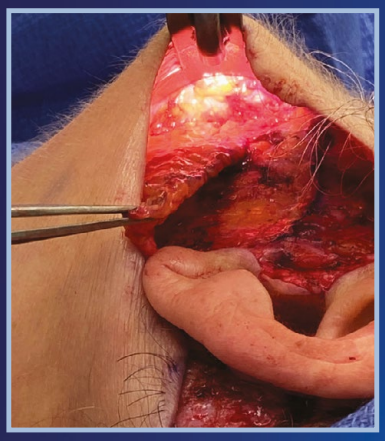

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DENYS MONTANDON, MD – SWITZERLAND

LOUIS APPIA (1818–1898): PIONEER OF HUMANITARIAN SURGERY AND CO-FOUNDER OF THE INTERNATIONAL RED CROSS

Nowadays, countless surgeons all over the world, and in particular plastic surgeons, engage in humanitarian missions to offer their skills and help the neediest in countries that do not have the financial and human resources to ensure the treatment of a number of patients. These interventions, often coupled with providing teaching to local surgeons, have improved health, body integrity, and quality of life for children and adults who would otherwise never have had access to this care. While some surgeons are involved on a personal basis, sometimes expatriating for a long period of time, most often the missions are organized and financed by charitable associations and focus on one or another area of a surgical specialty.

As far as plastic and maxillofacial surgery is concerned, the book by Dr. Hervé Bénateau, *L'Humanitaire en Chirurgie Maxillofaciale et en Chirurgie Plastique* (Humanitarianism in Maxillofacial and Plastic Surgery)[1], written by a number of French-speaking surgeons, gives a good idea of the history, organization, experience, and complexity of plastic surgery missions in African countries. It is also important to recall the foundation in 1956 of the Flying Doctors, also called African Medical and Research Foundation (AMREF), by three exceptional plastic surgeons – Sir Archibald McIndoe, Dr. Thomas Rees, and Sir Michael Wood – accounted with talent by Dr. Rees in his book *Daktari, a Surgeon's Adventures with the Flying Doctors of Africa*[2].

WAR SURGERY

Surgery on the war-wounded, whether performed on combatants or civilians, is not strictly speaking a humanitarian surgery. Indeed, since the earliest times, surgeons who were hired to accompany the troops in battles did not engage voluntarily but were incorporated in the militaries, usually as officers. This practice was well developed in the Roman armies, as it is recalled in several ancient Latin texts[3]. With the introduction of firearms and the advent of bullet wounds, a few highly renowned surgeons of the Renaissance, such as the Italian Bartolomeo Maggi (1477–1552) or the French Ambroise Paré (1510–1590), left us testimonies of their intense activity and experience in the care of the war-wounded. The best example of a military surgeon has been given 300 years later during the Napoleonic Wars by Baron Dominique-Jean Larrey (1766–1842), generally regarded as the originator of modern military trauma care and of what would become known as "triage". He placed surgical teams near the front lines to shorten the time elapsed after injury and instituted specially designed horse-drawn "flying ambulances", in which the

wounded rode with an early version of emergency medical technicians. Larrey was beloved by the French soldiers for his dedication to the troops in the coldness and desperation of the battlefields. As other war surgeons of his time, he would exceptionally treat civilians or wounded from the enemy camp, but he was principally a military officer at the service of the French Emperor.

LOUIS APPIA

The life trajectory, contributions, and motivations of surgeon Louis Appia related to war surgery several years after Larrey, are very different ***(Figure 1)***. Born in Hanau, Germany, he obtained his doctorate at the University of Heidelberg with a thesis on esophageal stenosis. He first settled in Frankfurt where he treated the underprivileged population, participated in the fight against alcoholism, and opened an ophthalmological dispensary. An expert in first aid, he then went to treat the wounded during the revolutions of 1848 in Paris and Frankfurt. Settled in the city of Geneva since 1849, he quickly became involved actively in the local medical society and published several studies on eye vision, and chronicles on the diseases affecting the canton of Geneva. In the spring of 1859, the Italian War broke out, pitting the Sardinian and French armies against those of Austria-Hungary. Sensitized to war surgery by his former experiences, he left for Solferino in 1859 to help the Italian military surgeons. He visited the hospitals in Lombardy, recording the results of his medical observations.

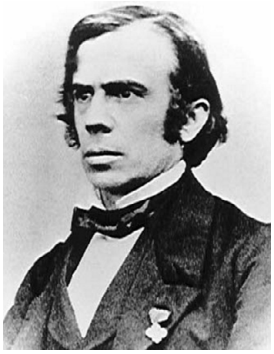

Figure 1. Surgeon Louis Appia

On his return, he published in French a whole treaty on war surgery, *Le chirurgien à l'ambulance ou quelques études pratiques sur les plaies par armes à feu, suivi de lettres à un collègue sur les blessés de Palestro, Magenta, Marignan et Solférino*, which was later translated in English and published in 1862[4]. He also designed inflatable splints, to secure the fractured limbs, and a device for transporting the wounded ***(Figure 2)***. Back in Geneva, he launched immediately through the newspapers a collection for the wounded soldiers.

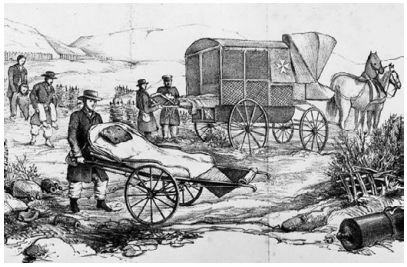

Figure 2. Ambulance and care of the wounded on the battlefield, drawn by Louis Appia.

THE FOUNDATION OF THE ICRC

A few weeks after the testimony of Appia, another citizen of Geneva, the businessman Henry Dunant, traveled to Italy to meet the French emperor Napoléon III. When he arrived in the small Italian town of Solferino, he witnessed the aftermath of the Battle of Solferino where, in a single day, about 40,000 soldiers on both sides died or were left wounded on the field. Henry Dunant was shocked by the terrible aftermath of the battle, the suffering of the wounded soldiers, and the near-total lack of medical attendance and basic care. Back in Geneva, he decided to write a book entitled *A Memory of Solferino*[5], with the help of Louis Appia for medical matters. In a Europe shaken by conflict, the vision and founding principles of the Red Cross emerged, as written in Henry Dunant's book. Thanks to the meeting of five Genevans – Henry Dunant, Gustave Moynier, the Swiss General Guillaume-Henri Dufour, Théodore Maunoir, and Louis Appia – who were united by the same indignation at the fate of wounded soldiers and an equal determination to act, these principles were to take root in action. This **Committee of Five** constituted itself as the founding International Committee of the Red Cross (ICRC) on February 13, 1863, and convened a first international conference in October. During this constitutive conference, Louis Appia proposed that all relief workers wear the same white armband (the "Red Cross"), that healthcare was to be neutral without taking care of the soldier's appurtenance, and that voluntary civilians could participate in the sanitary care ***(Figure 3)***. Soon after the creation of the ICRC, Louis Appia was the first delegate sent by the International Committee to a theater of war. On this mission in Schleswig, during the Duchy War (1864) between the German Confederation and Denmark, he was greeted by Marshal Wrangel, commander of the Prussian army, with these words, ***"The sign you are wearing [the red cross armband] is a sufficient recommendation; we know what it means, you are here for the general welfare."***

Figure 3. The red cross armband, promoted by Appia.

This experience fed into the report on the first steps of the institution that Louis Appia sent to the ICRC on the eve of the Diplomatic Conference of August 1864, where 12 States signed the *First Geneva Convention for the Amelioration of the Condition of Wounded in Armies in the Field*. Commissioned in 1866 by the Red Cross of Milan, Appia returned to the front line in 1866, at the head of an ambulance that went to the wounded of the Italian army led by Giuseppe Garibaldi[1] in Bezzecca, in the Tiarno valley. Three years later, he returned to the field during the Franco-Prussian war of 1870.

THE HERITAGE OF LOUIS APPIA

Louis Appia spent the rest of his life practicing medicine and surgery in Geneva. Author of medical publications, often inspired by the experience acquired in the theaters of war, he established himself as a leading theorist of military humanitarianism. As a witness to the suffering endured by populations during armed conflicts, he took a position very soon after the creation of the ICRC, and against the advice of his peers, in favor of extending the institution's mission to civilians. Appia was not only a theoretician, a defender of the principle of neutrality which was to become the cornerstone of the International Red Cross, he was also a man of the field, a war surgeon.

Each mission is reported in detail in publications. His humanitarian commitment, served by a great evangelical faith, did not stop at the Red Cross. He was an ardent promulgator of public hygiene and the care of children. He advocated ventilating rooms, avoiding stagnant water, and frequently washing children. Following closely the progress of science, and promoting the fight against infections, he wrote in 1883, *"Let us greet the new era that is opening for hygiene and let us end with this war cry: death to microbes."*

"What would I say to men like you, whose sublime mission is the relief of suffering humanity? To you, whose devotion has contributed so much to alleviate the sufferings of my wounded comrades – may God bless you and all the men who belong to your holy institution. I will be happy if you want to consider me, forever, your devoted and grateful confrère."

G. Garibaldi

(Letter from G. Garibaldi[1] to Louis Appia, originally written in French)

FOOTNOTE

1. Giuseppe Garibaldi was an Italian General and revolutionary who contributed to Italian unification.

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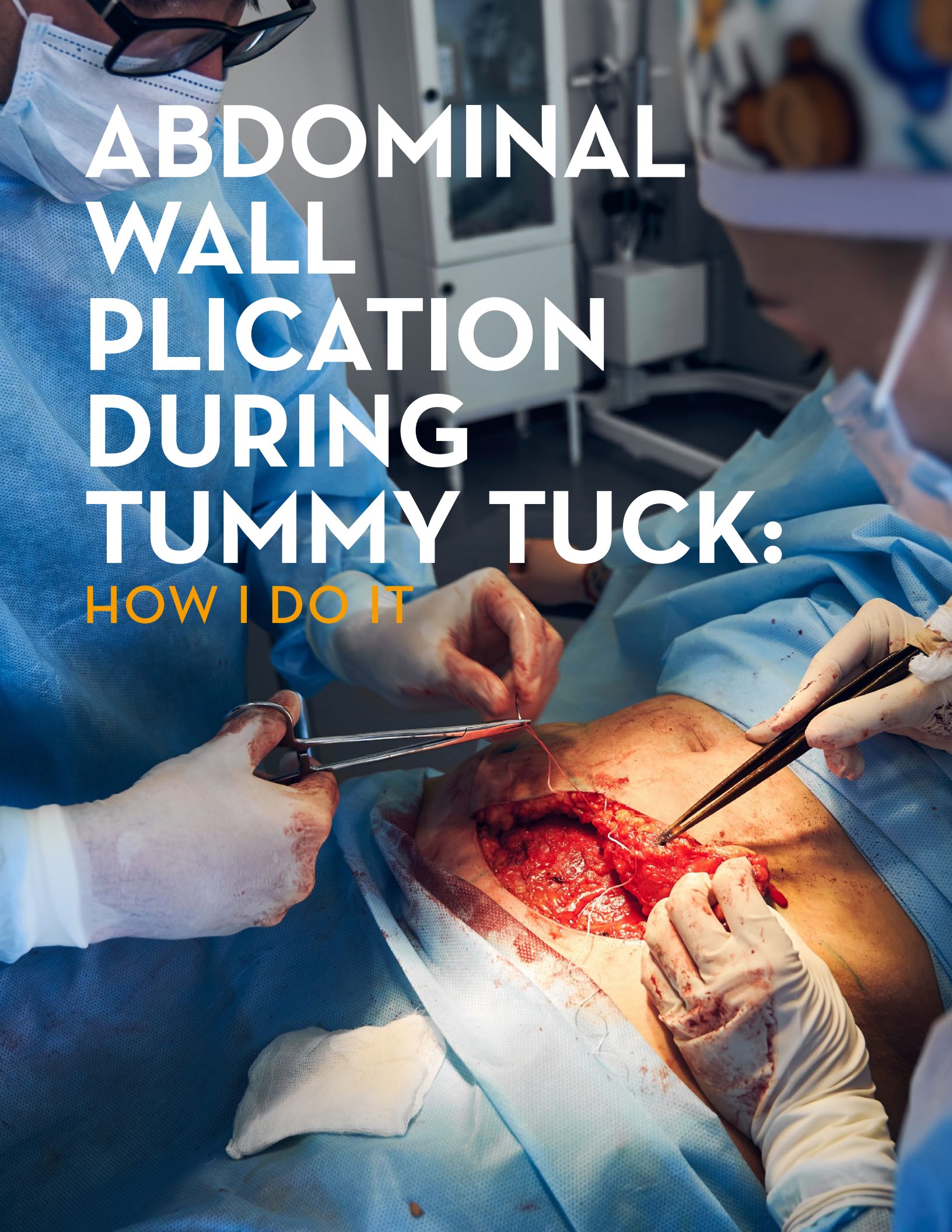
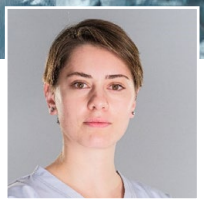


ABDOMINAL WALL PLICATION DURING TUMMY TUCK:

HOW I DO IT



MARIAM TSIVTSIVADZE, MD – GEORGIA

KONSTANTIN SULAMANIDZE, MD – GEORGIA

The abdominal wall is an anatomical structure responsible for the protection of the abdominal viscera. Plication of the anterior rectus sheath is the most used technique to repair diastasis recti and this surgical procedure is usually performed during tummy tucks. The diastasis of the rectus abdominis muscle is responsible for the protrusion of the abdominal wall, and hernia formation[1]. Different techniques have been proposed for the treatment of deformities caused by laxity of the abdominal wall musculature.

Surgeons have created different types of plications in the anterior abdominal wall, the majority of these being vertical plications that aim to correct rectus diastasis. Different types of sutures have been utilized in plication and correction of rectus diastasis[2]. The current literature provides sufficient data to recommend correction of abdominal diastasis with different type of sutures, absorbable and non-absorbable, in the size range 0 to 2-0 being favored. Muscle advancement should be performed with non-absorbable sutures because these structures are subjected to stronger tension after the operation.

The indication that diastasis recti must be repaired is based on a patient's symptoms and physical examination findings. Optimal management varies and includes simple plication of the midline defect, and extensive plication of the anterior abdominal wall etc. For mild to moderate diastasis recti, midline plication of the linea alba can be considered while, in patients with significant laxity of the anterior rectus sheath, lateral plication can also be performed on both sides to further improve and tighten the abdominal contour[3].

In our practice, we mainly use a single-layered running suture for plications, using a non-absorbable (polypropylene) 25 cm and 50 cm bidirectional barbed suture ***(Figure 1)***. The thread length chosen depends on the area to be covered (supraumbilical or infraumbilical region, or both); 25 cm is enough to cover either region while 50 cm is needed to suture both. As the thread itself has a knot at the end, this ensures the first suture in the umbilical region is locked in place. There is therefore no need for locking in every bite as sutures are fixed immediately during the stitching process, due to the bidirectional barbs along the thread.

Figure 1. Non-absorbable polypropylene bidirectional barbed suture 2.0 for abdominal wall plication.

HOW WE DO IT

A narrow tunnel is undermined in the supraumbilical region, extending laterally to the line 1 cm from the medial edges of the rectus abdominis muscles. The limits of the diastasis recti are marked with methylene blue and the distance between the medial edges of the rectus abdominis muscles (inter-recti distance) is measured with a ruler at the same supraumbilical and infraumbilical levels ***(Figure 2)***. We continue repairing the diastasis with a single layer by running, non-absorbable, bidirectional barbed sutures, starting in the middle of the supraumbilical region and running the suture up and down until we reach the end of the diastasis, then using the same suture to the infraumbilical

Figure 2. Intraoperative picture: management strategies for diastasis recti – marking of supra- and sub-umbilical region.

Figure 3. Intraoperative picture: after repairing midline diastasis above and below the umbilicus with running suture.

region without splitting ***(Figure 3)***. As previously mentioned, there is no need to lock the thread once the suturing is completed.

In conclusion, plication of the anterior rectus sheath, with a bidirectional barbed suture in a single layer, is a rapid and efficient method to repair diastasis recti which only requires a short operative time. A technique that provides a reliable correction of abdominal deformities with long-term results is highly desirable in abdominoplasty.

"DUAL-PLANE" DIASTASIS PLICATION

VLADISLAVA GLADYSHEVA, MD – RUSSIA

Diastasis recti abdominis application of the anterior abdominal wall muscles is a very routine stage of abdominoplasty; at the same time, diastasis plication is the only surgical manipulation that forms the result of abdominoplasty for certain patient categories. These patient groups include those with low body mass index (>18–20), and subcutaneous fat deficiency. The patients with low body mass index are characterized by relatively low stomach location which, along with myofascial insufficiency, is a deforming factor. Myofascial weakness of the anterior abdominal wall develops most often after multiple pregnancies and the deformation occurs in two planes: horizontal (divergence of the rectus abdominis muscles), and vertical (their lengthening).

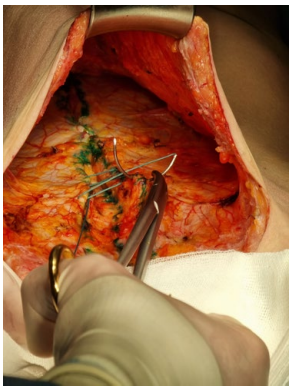


Figure 1. Corset-like sutures on the rectus muscles. Three bites are made on each side of the medial aspect of the muscle.

The method we use for suturing the distal rectus abdominis has been named "dual-plane", i.e., the classically used two rows of sutures have not only a protective function, but also a treatment of vertical muscle elongation in the first row of sutures. Dual-plane plication of the diastasis is performed all the way from the xiphoid process to the pubic symphysis. The first row of sutures is the corset-like muscle shortening type. Three bites are made on the medial part of the right and left rectus abdominis muscles ***(Figure 1)***. The suture is tied, bringing the first and sixth stitches closer together, thereby shortening the length of the muscle ***(Figure 2)***. The number of stitches varies depending on the length of the muscle and its weakness. The thread used for this first row of sutures is the Ethibond 2-0.

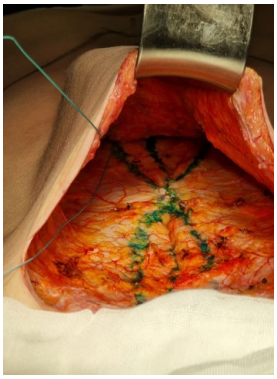


Figure 2. Tied-up corset-like sutures for muscle approximation and shortening.

After the first row is completed, the diastasis is sutured throughout but it is important to remember that such sutures can be felt by patients, especially those deficient in subcutaneous fat. This next second row of sutures is therefore the intra-aponeurotic continuous incision type which approximate the muscles in the horizontal direction, strengthen the imposed corset-like sutures, and camouflage the sutures so that they are not visible even in the case of the skinniest patients ***(Figure 3)***. The thread used for this second row of sutures is the PDS 1-0 loop.

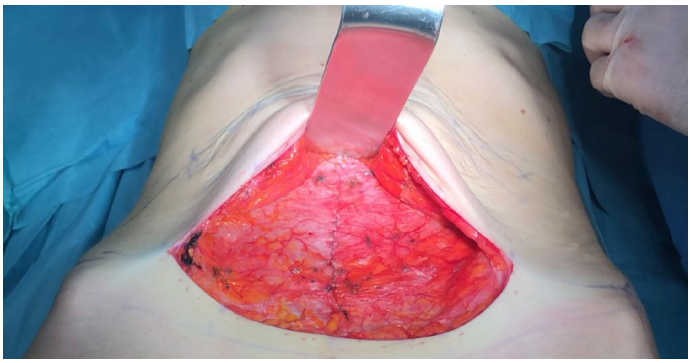


Figure 3. Second layer of sutures: intra-aponeurotic continuous incision suture.

ABDOMINOPLASTY IN BAKU, AZERBAIJAN: WHY I CHOOSE THIS TECHNIQUE

KHAYAL JAFAROV, MD – AZERBAIJAN

This article is intended to highlight the steps used in every abdominoplasty I perform. For the majority of my patients needing abdominoplasties, I will routinely perform liposuction in the first instance using the necessary lipomatic equipment ***(Figures 1, 2)***. I adopt the hydrodissection technique to the area that I plan to remove during the abdominoplasty, so as to loosen the fat cells from the area needing tightening.

Figure 1. Liposuction after starting the tummy tuck, with the help of the apparatus lipomatic sp 7.

Figure 2. Liposuction using the apparatus lipomatic sp 7 to create anatomical lines of the anterior abdominal wall.

The benefit of undertaking this procedure is that, in turn, it will better facilitate the tightening of the front part of the abdomen during the abdominoplasty.

I make a horizontal incision located 8 cm higher from the start of the pubis. Then, I complete a full dissection to the xiphoid not reaching 1–3 cm. Following on from that, I restore the diastasis of the rectus abdominis muscles, in the vertical direction, pressing down on the midline while sewing the edges of the rectus muscles. After completion, the next step is to create a new navel position. When choosing a new site for the navel, it is very important to also dissect the subcutaneous fat from the bottom and the top of the navel, in order to create a retracted appearance. Sewing the edges of the navel is achieved using the monocryl suture, size 3/0.

The next important consideration is the optimum position of the operating table for the abdominoplasty, so that the state of the patient is approximately 140–150 degrees (almost looking like the letter "V"), as this optimum position reduces the amount of stretching that occurs to the skin of the anterior abdominal wall.

We then move on to sewing the fascia, subcutaneous fatty tissue, and skin, using the skin relaxation method for the subcutaneous fatty tissue, and intradermal sutures for the skin. If a large hemorrhage occurs during hemostasis, I use the drainage method and attempt not to cauterize the tissue.

The advantage of this technique is that, after removal of the excess fat cells, the sagging skin of the anterior abdominal wall is easily removed and the tension of the suture line is reduced, leading to maximum invisibility of the suture marks.

The author has no financial interest in any company or product named in this article.

INTERNAL WAIST TRAINER

FRANK AGULLO, MD – UNITED STATES

Abdominal muscle plication is an essential part of an abdominoplasty. Laxity of the supporting musculofascial network of the abdominal wall is widespread after pregnancy or weight gain. The maximum abdominal protuberance is usually in the lower abdomen, where there is an absence of a posterior rectus fascia below the arcuate line. Nevertheless, there is fascial laxity in the abdominal wall circumferentially.

Historically, medial vertical plication from xiphoid to pubis has outlasted other methods to correct abdominal laxity[1]. Proposed modifications in plication include vertical rectus and bilateral oblique plications[2,3], horizontal complementary plication[4], plication in an H shape[5], two vertical fusiform plications[6], transposition of the oblique muscle aponeurosis[7], and transverse rectus sheath plication[8]. Previously described in the literature, the longitudinal rectus fascia and bilateral oblique fascial plications result in an improved waistline compared to other methods[2,3]. This has also been my experience, with more than 1,000 abdominoplasties.

Waist trainers and corsets aim to accentuate the waistline. They usually have more than one seam – not only one down the middle in the front but, typically, a seam running parallel on both sides. The extra seams allow for a three-dimensional approach to a more accentuated waistline while distributing the tension. If the midline is plicated only below the umbilicus, it results in epigastric bulging. You can also observe this phenomenon in the oblique areas after making a total central plication. This deformity is easily repaired with oblique plications.

I perform a typical vertical plication of the rectus fascia from xiphoid to pubis and fusiform plication of the oblique fascias ***(Figure 1)***, each done with 0 looped PDS (polydioxanone). There have been no significant statistical differences in using PDS versus a non-absorbable suture[9]. I restrict patients to less than 32 BMI and I am more conservative on patients with increased intra-abdominal fat.

Many surgeons are hesitant to perform the triple plication because of fear of increased intra-abdominal pressures, and the belief that they can achieve good waist contouring with the midline plication alone. Before performing the abdominal plications, we obtain a baseline peak inspiratory pressure at a set volume of 500 ml. This measurement reflects the effects of increased intra-abdominal pressure on increased peak inspiratory pressure and decreased lung volumes directly. While performing the abdominal plications, we continue to monitor the inspiratory pressures. The midline plication increases the inspiratory pressures much higher than the oblique plications. We have found that maintaining inspiratory pressures under 26 cm H_2O, at a volume of 500 ml, eliminates respiratory complications from increased intra-abdominal pressure.

Although the central plication can be exaggerated to bring the obliques towards the midline, this technique increases intra-abdominal pressure to a higher degree. In addition, when the plication becomes significantly more expansive, it can disfigure the anatomy of the rectus muscles.

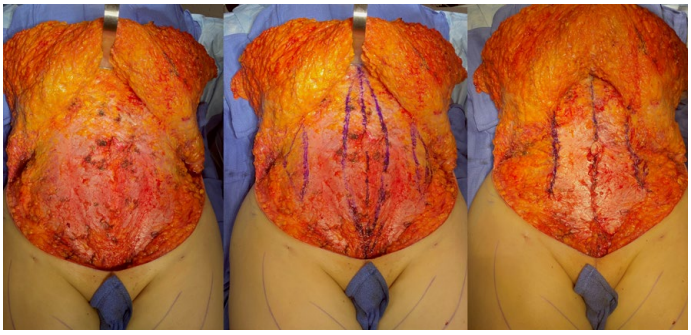
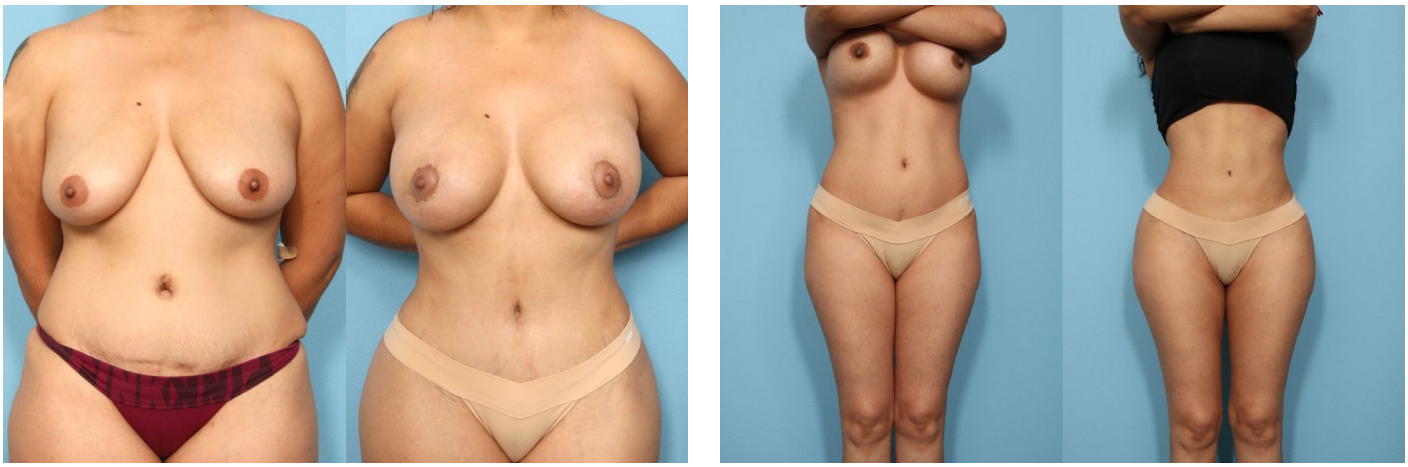


Figure 1. Markings and the triple plication.

I demonstrate the difference that can be achieved in waist contouring in two patients who had undergone a traditional single plication abdominoplasty ***(Figures 2, 3)***. Use of triple plication during abdominoplasty results in improved tension of the entire abdominal wall, enhancement of the waistline, and improvements in the uniformity of the contour of the anterior and lateral view which are maintained at long-term follow-up.



Figures 2, 3. Patients with a previous abdominoplasty with single midline plication from another surgeon. Results six months after revision with triple plication.

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TULUA: TRANSVERSE PLICATION ABDOMINOPLASTY

FRANCISCO J. VILLEGAS, MD – COLOMBIA

A radically different type of abdominoplasty is my current approach. I do infraumbilical wide transverse plicature, as part of the TULUA procedure, which has NO flap undermining above the umbilicus, has unrestricted liposuction, and has controlled (planned) positioning of the scar and neoumbilicus ***(Figures 1-3)***.

Figure 1. TULUA liposuction without restriction. En bloc resection and umbilical amputation.

After studying the history and scientific reasoning behind the main trends in abdominoplasty, the procedure was created and indicated in selected cases since 2005.

Successive publications in peer-reviewed journals demonstrated good aesthetic results, diminished complications, and growing indications. The procedure has an easy learning curve and many surgeons are using it because of its simplicity and safety.

Tuluá, the name of the city in Colombia where the idea was born, is used for the procedure's acronym:

T **T**ransverse plication
U no **U**ndermining above the umbilicus
L full unrestricted **L**iposuction
U neo**U**mbilicoplasty
A **A**bdominoplasty

Advantages, supported by published clinical and animal experiment studies, are:

1. Technical simplicity, reproducibility, and ease of performance.
2. Vascular flap safety because of perforator vessels preservation.
3. Unrestricted liposuction, including epigastric region prohibited by other techniques.
4. Free positioning and good neoumbilicus shape.
5. Very low abdominal scar positioning.
6. Comprehensive correction of abdominal wall laxity, due to massive transverse plication without compensatory bulging in the epigastrium.
7. Waistline improvement as a result of downward and midline traction of inferior border of external oblique muscles caused by wide horizontal plicature.
8. Less dead space and tension in abdominal wound closure ***(Figure 2)***.

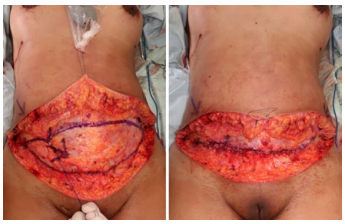


Figure 2. Transverse plication: integral correction of wall laxity, advancing external oblique muscles and improving waistline.

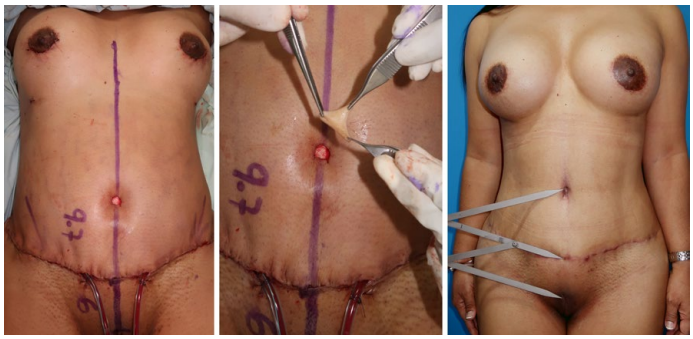


Figure 3. Neoumbilicoplasty with a skin graft. Free positioning of umbilicus; adequate proportionality.

9. Uniform distribution of epigastric skin, avoiding "dome effect" with tissue accumulation in midline seen with vertical plication.
10. Satisfactory, consistent, and reproducible quantified aesthetic results ***(Figure 4)***.
11. Expansion of indications to patients with umbilical hernias, subcostal scars, post-bariatric and aesthetic closure of donor abdominal flaps (TULUA-DIEP).
12. Application to a wide variety of primary cases, ranging from typical post-pregnancy deformity without visible or palpable diastasis, to the most exigent patients, i.e., male athletes and females with high-definition liposculpture expectations (TULUA-HD).
13. Used in follow-up cases due to poor primary procedural results or complications, facilitating a full infraumbilical secondary resection.
14. Useful correction of abdominal liposuction sequelae as retractions, chronic seromas, irregularities, or residual skin excess.
15. Measured complications in a similar range to other lipoabdominoplasty techniques, but with fewer vascular-related problems.

Figure 4. TULUA lipoabdominoplasty: typical case results.

However, TULUA also has its disadvantages:

1. Skin graft "take" of neoumbilicus can be delayed or not integrated in around 10% of cases.
2. Long term, neoumbilicus can migrate upwards by about 1–3 cm, possibly due to plicature elongation.
3. High misplaced umbilicus is possible if anterior point is not anticipated, and careful planning not performed during surgery.
4. Diastasis recti are not fully addressed or completely corrected. However, in cases of pathological diastasis, it can be combined with a vertical plicature through a limited midline tunnel dissection to add to both techniques' benefits (TULUA-NHA) ***(Figure 5)***.

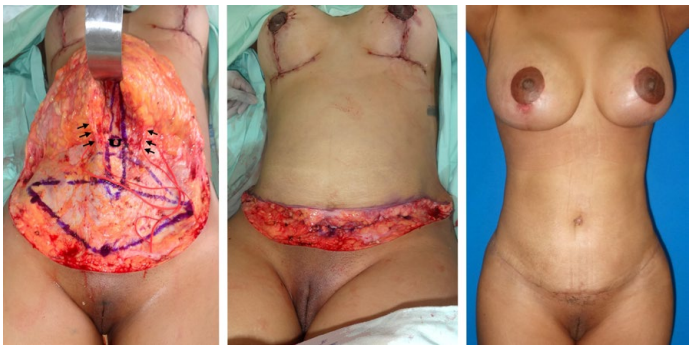
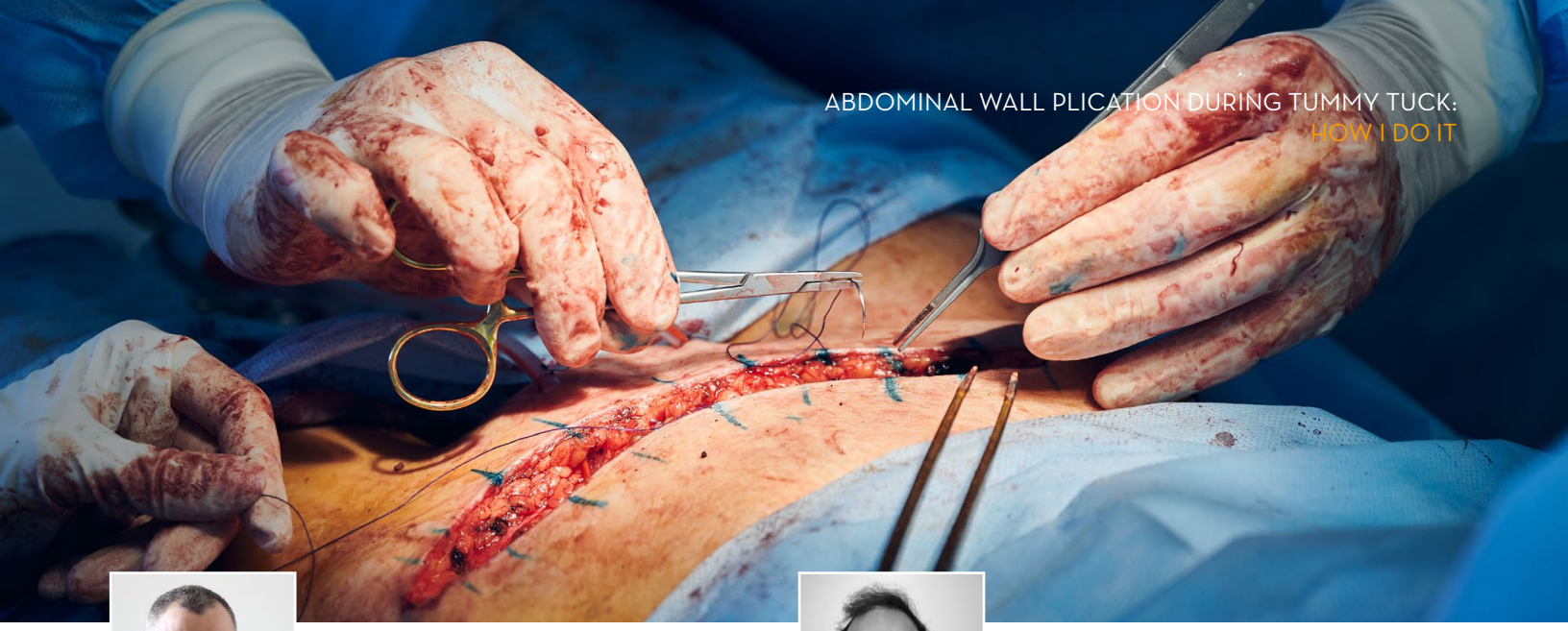
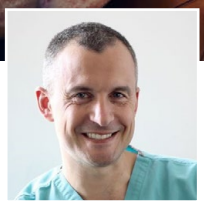


Figure 5. TULUA-NHA: Vertical and transverse plicatures to correct pathological diastasis.

TULUA could be globally accepted by most surgeons in the upcoming new surgical era, providing them with the solution to their tireless search for simplicity, safety, good results, and an effective liposuction with abdominoplasty combined procedure.





FULVIO URSO-BAIARDA –
UNITED KINGDOM

WILL COBB –
UNITED KINGDOM

ABDOMINAL WALL PLICATION DURING TUMMY TUCK

Rectus abdominus divarication exceeding 25 mm is common in patients seeking abdominoplasty, particularly in postpartum women. Repair of the divarication is a key component of surgery and can have functional benefits including improved core strength and reduced back pain, in addition to aesthetic improvements in restoring normal anatomy and reducing truncal circumference.

In order to achieve aesthetically pleasing abdominal contours, it is important to ensure the recti are closely approximated, minimize risk of muscle repair failure, and accentuate naturally-occurring areas of relative adherence above the muscle aponeuroses, namely the linea alba and linea semilunaris. Patients with >2 cm pinch thickness residual adipose are unlikely to achieve visible muscle definition and it is our practice to include adjunctive power-assisted liposuction (PAL) where pinch thickness exceeds this (i.e., the majority of cases).

Combined PAL and abdominal wall plication are used both for reduction in overall abdominal flap thickness and for regional contouring by targeted combined treatment. We experience good results in reconstructing the "champagne groove" (upper midline indentation) and the semilunar contours in this way. Our strategy involves firstly performing PAL to reduce pinch thickness, then raising the abdominal flap with only a suprafascial tunnel to expose the recti above the umbilicus. For the muscle repair, we then perform a three-layer repair above the umbilicus, and two layers below.

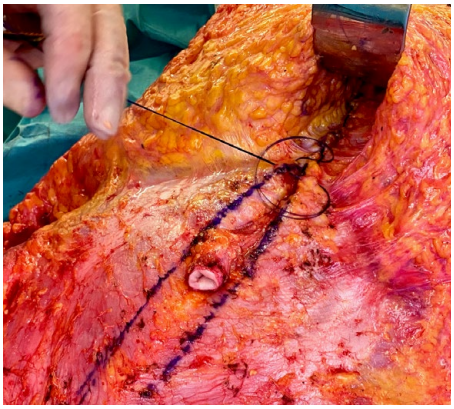


Figure 1. 1st suture layer, continuous locking mattress with 1 Loop PDS.

- We use a 1 Loop PDS in view of high tensile strength and absorbability, preferring absorbable sutures to reduce any patient concerns regarding knots felt on deep palpation, although the suture technique itself tends to help bury knots within the muscle sheath ***(Figure 1)***.
- Above the umbilicus, we utilize a continuous locking mattress suture to approximate the edges of the recti, commencing in a cranial-caudal direction and

leaving adequate space to prevent umbilical ischemia.

- The suture is tied off using an Edinburgh knot but without cutting the excess suture, avoiding any risk of knot failure.
- A second layer of muscle repair then proceeds from caudal-cranial, using the same suture as an inverting horizontal mattress, ensuring the deeper suture is completely buried including knots ***(Figure 2)***.
- The suture is tied at the cranial end in the same fashion, again without cutting the excess suture.
- A final continuous layer from cranial-caudal proceeds (with the same suture), securing the deep fascia of the abdominal flap to the muscle sheath, to close deadspace and reconstruct the midline "champagne groove" ***(Figure 3)***.

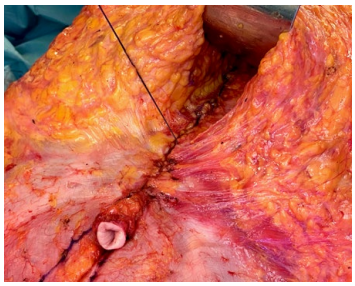


Figure 2. 2nd suture layer, inverting horizontal mattress.

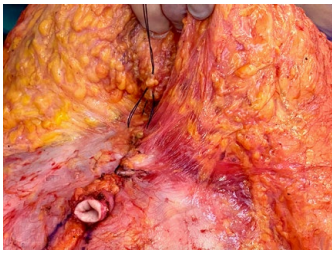


Figure 3. 3rd suture layer, quilting deep fascia to muscle sheath.

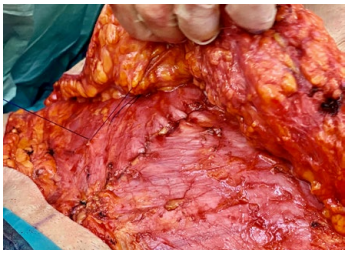


Figure 4. Semilunar line suture plication.

- Below the umbilicus, the first two layers are repeated as above. A third layer is unnecessary here as, in our experience, a continuation of the midline groove is not desirable and looks unattractive, creating an appearance reminiscent of abdominal festoons.
- Further plication/quilting of the abdominal flap in the orientation of the semilunar lines is then performed. This serves several purposes: sculpting the semilunar lines, recruiting lateral skin laxity, and accentuating the waist. Furthermore, deadspace and risk of seroma formation is reduced, and the lower abdominal scar is improved by distributing tension more evenly across the abdominal flap ***(Figures 4, 5)***.

Figure 5. Final results (patient's own images immediately before and two months after surgery).

CORRECTION OF DIASTASIS RECTI ABDOMINIS

JESÚS BENITO-RUIZ, MD – SPAIN
ISAPS National Secretary

Diastasis recti abdominis (DRA) was defined as a separation of the rectus muscles of more than 2 cm with three categories (<3 cm, 3–5 cm, and >5 cm)[1], with no fascia defect. DRA is characterized by a protruding midline as a result of an increase in intra-abdominal pressure[2]. DRA involves a gradual thinning and widening of the linea alba, combined with a general laxity of the ventral abdominal wall muscle. In the general population, the prevalence of DRA is as high as 57%. Age, BMI, and parity are independent risk factors for DRA[3].

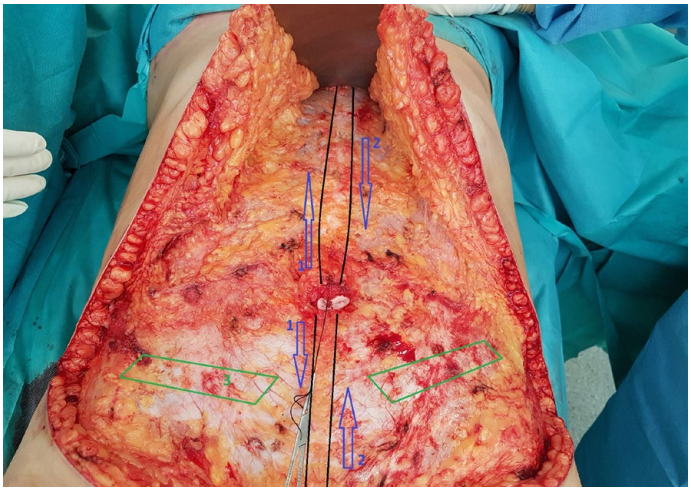


Figure 1. Plication of recti abdomini begins above umbilicus, towards xiphoid, closing the gap[1] then coming back, tightening the wall by taking wider bites of tissue. The same is performed at the infraumbilical diastasis[2]. If needed, a transverse plication of the external oblique is performed, with the patient sitting up in the operating table[3].

Correction of DRA is a usual step in abdominoplasty; suturing (plication) is the commonest technique. In severe DRA, a mesh could be used with good results[4]. So far, I have never had a case where a mesh should be used to correct the DRA. However, in some cases I have found an epigastric hernia or umbilical hernia, where a plug of polypropylene has been used to seal the defect.

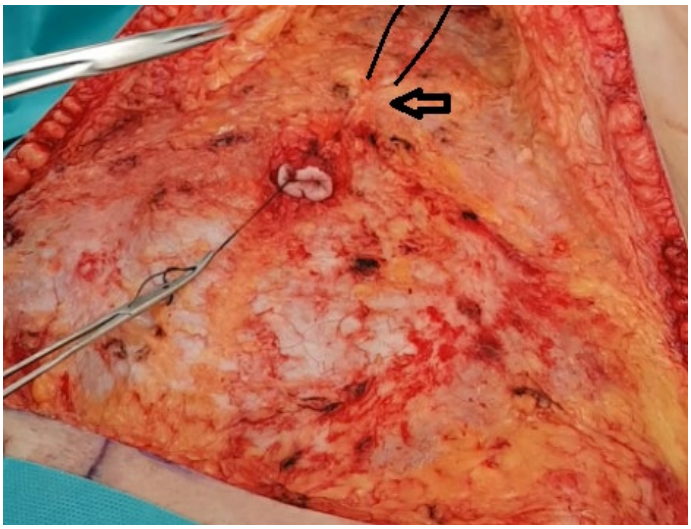


Figure 2. Upper plication: the first row is edge to edge.

For years, I used single stitches of non-absorbable suture (polyethylene, Ethibond™), however I had a number of thin women where the suture was palpable. Nowadays, I use a resorbable, monofilament, barbed suture with unidirectional spikes (2-0 V-Loc™, 2-0, 26 mm ½ circle, round needle, 30 cm, copolymer of glycolic acid and trimethylene carbonate, Covidien). This thread resorbs in 180 days – its main advantages are:

- no knots;
- reduction in surgical time;
- homogeneous distribution of tension.

I start at the supraumbilical area, moving cranially from the umbilicus to the xiphoid (closing the gap) and coming back from the xiphoid to the umbilicus (tightening). Tightening is performed by taking wider bites of the aponeurosis recti. This running suture crosses the first row, and in the end we get a criss-cross suture and tight abdominal wall. At the

infraumbilical section of the diastasis, the suture runs from the umbilicus to the pubis and comes back ***(Figures 1-4)***.

Once this step is over, the plication is checked by palpation and, if any holes or weak areas, I reinforce with an inverted, single stitch of 2-0 Vicryl suture. In patients with a very weak abdominal wall, a transverse bulge may appear with the patient sitting up on the operating table. In these cases, I perform a transverse plication of the oblique muscle before doing the advancement and skin closure. I always do a TAP block with bupivacaine 0.25% to reduce postoperative pain.

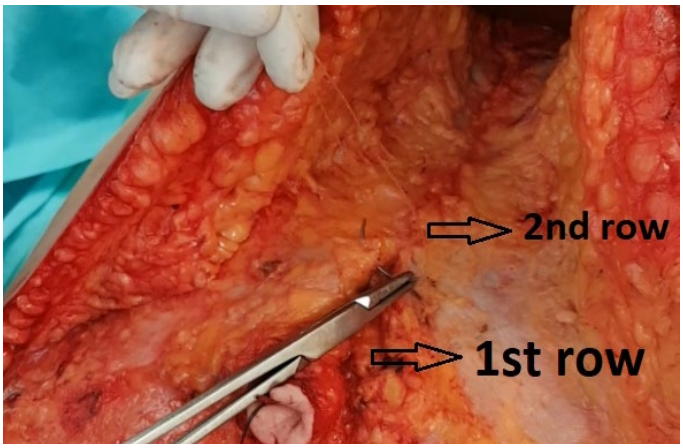


Figure 3. The second line tightens the fascia. The arrows show the first line of plication (deeper) and the second one used for tightening.

Figure 4. Lower plication.

The author has no financial interest in any company or product named in this article.

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HOW I PLICATE ABDOMINAL MUSCLES DURING ABDOMINOPLASTY

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ISAPS National Secretary

Abdominoplasty is a procedure indicated for patients with a specific deformity when the components of skin laxity, excess of abdominal fat, and laxity of abdominal muscles are consistent as well as varied in their severity.

While external and internal fat can be addressed by either dieting or liposuction, and skin can be addressed by excision, muscle diastasis can only be repaired surgically by plication. The severity of this deformity was originally classified by Dr. Fabio X. Nahas[1] in 2001. This classification also describes the plication technique from simple suturing to manipulation of the muscle layer. Patient selection and choosing the right technique is important to attain the desired outcome.

Recently, the use of synthetic mesh can be used to enhance the strength of the repair, providing the specific complications can be avoided or minimized. The Lockwood technique[2] of suturing the external fascial layer can also enhance the aesthetic results for the correctly chosen patients.

My personal approach to plication of the abdominal muscle is based on traditional principles of using non-absorbable loop-nylon sutures which allow double strength of the suture to repair the strong abdominal muscular layer. The choice of the suture comes from the proven minimal complication surgical technique for closing the abdominal wall after laparotomy.

After dissection of the abdominal flap from the symphysis pubis up to the xiphoid process, the whole linea alba is exposed. Assessment of the extent of facial repair required is done by checking the fascial laxity while the patient is under general anesthetic. It is important to make sure that the patient is completely relaxed during the marking and the repair, without the possibility of tensing abdominal wall muscles.

Simply bringing the edges of the estimated repair with forceps allows one to judge the tension of the repair. The marking of the repair is done using a surgical marker, the shape of the design usually resembling one supra and one infraumbilical ellipse. The marking is just an estimate and can be modified during the actual repair.

I use continuous locking sutures from the xiphoid to above the umbilicus and tie the multiple knots to bury them in the muscle, as this helps hide any irregularities caused by having thick sutures with multiple knots at the end. For the infraumbilical part of the procedure, I restart the continuous suture again, so as not to cause any constriction of the umbilical stalk. It is important to avoid any ischemia of the umbilical stalk or the umbilicus itself. I do start the infraumbilical part of the repair again with a buried knot below the umbilicus and I finish with one just above the symphysis pubis. The continuous locking suture is used so as not to cause a concertina effect on the muscle repair.

On thinner patients with just skin excess and an ill-defined waist, I use a lateral oblique muscle plication suture, using a coated polyglactin braided suture, as that usually ensures better waistline contouring resulting in the appearance of an hourglass figure. On patients requiring a large abdominal dissection, due to excess skin laterally over the iliac crest, I use a quilting suture with polyglactin-coated braided

suture as this ensures less dead space and minimizes fluid accumulation, thus avoiding seroma formation. I do try to avoid using a synthetic mesh unless the diastasis recti is more than 10–12 cm in width, depending on the size of the patient, or the patient is overweight with a large amount of intra-abdominal fat.

The most troubling after-effect of abdominal muscle plication is abdominal compartment syndrome. This complication is preventable by undertaking an intraoperative assessment of the tightness of the repair. Close observation of the patient after contouring of the abdomen is always needed for 24–48 hrs post-surgery to look out for subtle signs of a possible increase in intra-abdominal pressure.

The average result of abdominoplasty without any truncal liposculpting is presented in ***(Figure 1)***. The first two pictures (from left to right) show the patient before the procedure, including pre-operative markings, while the picture on the right illustrates the patient after one year, showing an improvement in the waistline and flat abdominal wall without protrusion and diastasis recti.

Figure 1. Abdominoplasty patient shown before and after procedure using loop nylon continuous locked suture.

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That is why, at GC Aesthetics® (GCA®), we are proud to have a 10-year post-marketing prospective clinical study with a large number of patients enrolled and several centers involved. Results showed low complication rates, demonstrating the long-term safety and efficacy profile through 10 years for GCA® round and anatomical silicone gel breast implants analyzed[1] ***(Figure 1)***.

Figure 1. GCA® round and anatomical silicone gel breast implants.

Another interesting clinical study has just been published[2], **led by Prof. Dr. Berend van der Lei in The Netherlands *(Figure 2)***, which **analyzes the "very" long-term (average follow-up 17 years) patient satisfaction and revision rate** of round micro-textured Eurosilicone Cristalline Paragel breast implants from a single center and single surgeon's experience.

It has been seen that, over time, the cumulative risk of capsular contracture increases, so a **significant longer-term evaluation study definitely adds important data to literature.**

Figure 2. Prof. Dr. Berend van der Lei, The Netherlands.

BACKGROUND AND STUDY METHODOLOGY

- A retrospective cohort study was undertaken of 84 patients who underwent primary breast augmentation with round micro-textured Eurosilicone Cristalline Paragel breast implants.
- The validated BREAST-Q questionnaire was used to analyze patient satisfaction.
- Implants were placed subglandularly or dual-plane through inframammary incision with a single surgeon and single center, with a minimum follow-up of 15 years.

- All surgeries were performed between January 2001 and December 2004.
- Long follow-up study: Average follow-up 17.03 years; range 15–19 years.
- Objective data regarding revisions, including capsular contracture, rupture rate, pain, and/or aesthetic causes needing revision surgery, were analyzed.

KEY FINDINGS OF THE STUDY

- High satisfaction rates were found, with BREAST-Q scores in the range of 67–100%.
- A significant difference between dual-plane and subglandular groups was found in psychosocial well-being in favor of the dual-plane group; however, this was not clinically relevant.
- This study showed high patient satisfaction rates and low revision rates.
- Average follow-up 17.03 years.
- No clinically significant differences were found between dual-plane and subglandular placement of implants.
- No cases of breast implant–associated anaplastic large cell lymphoma (BIA-ALCL) were noticed in the study as an indication for revision surgery.

CONCLUSION

This study[2] is significantly one of the longest follow-up studies on breast augmentation (average follow-up 17.03 years; range 15–19 years) in a single center, single surgeon setting, using round micro-textured Eurosilicone Cristalline Paragel breast implants (GCA®) in a dual-plane or subglandular location.

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Low Reported Kaplan-Meier estimated cumulative incidence of key complications at 10 years for round gel implants among the primary augmentation cohort*[5]

¥MemoryShape Post-Approval Cohort Study (formerly Contour Profile Gel Core Study) Final Clinical Study Report. Mentor Worldwide, LLC; 02 June 2015. MemoryGel Core Cel Clinical Study Final Report. Mentor Worldwide, LLC; April 2013. Mentor MemoryShape Post-Approval Continued Access Study (formerly Contour Profile Gel Continued Access Study), Final Report. October 2014. Mentor MemoryGel Breast Implant Large Post Approval Study Re-Op Phase Annual Report. 17 June 2016. Adjunct Study Final Report for Mentor's MemoryGel Silicone Gel-filled Breast Implants. 02 November 2012. Mentor MemoryShape CPG Styles Study: A Study of the Safety of the Contour Profile Gel Breast Implants in Subjects who are Undergoing Primary Breast Augmentation, Primary Breast Reconstruction, or Revision, Final Clinical Study Report. 20 October 2015.

§ Based on patient survey at 10 years in the Mentor® MemoryGel™ Breast Implant 10-Year Core Gel Clinical Study Final Report

* Not a head to head clincal study. Based on a comparison of 10 year core clinical study data for Primary Augmentation, Revision Augmentation, and Primary Reconstruction for MENTOR® MemoryGel® Breast Implants and NATRELLE™ Round TruForm1 Gel Breast Implants

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ISAPS CULTURE

MARIA L. MACIEL SOSA, MD – PARAGUAY

JESUIT MISSIONS ROUTE IN PARAGUAY

Known as Paraguay's best-kept treasure, the ruins of the Jesuit Guarani Missions represent an attraction that never loses its relevance. They invite admiration and a trip back in time, allowing us to imagine what life was like in Paraguay during the 17th and 18th-century Reductions, from the point of view of architecture, art, and religion.

Figure 1. The Jesuit mission of Santísima Trinidad del Paraná.

Several of these constructions have survived time so, for this reason, the Jesuit Route of Paraguay is a unique and unforgettable experience. The Jesuit mission of Santísima Trinidad del Paraná is the largest ruins – the best preserved today ***(Figure 1)***. This Reduction was founded in 1706, with a population of more than 3,000 indigenous people. The Jesuit architect, Bautista Primoli, was in charge of designing the entire Reduction, including the main church, considered to be one of the most attractive of the eight Reductions located in Paraguay ***(Figure 2)***. The Santísima Trinidad model is the same as the other Reductions – a Plaza Mayor around

Figure 2. The main church.

Figure 3. The Santísima Trinidad model including the church, cemetery, orchard & houses.

which the rest of the mission unfolds ***(Figure 3)***. In addition to the main church, there was a cemetery, orchard and, to the east of the church, houses for the indigenous people. In the temple's central nave, there was a crypt where several Guarani corregidores are buried.

The most visited are the ruins of San Ignacio Guazú, located in the Department of Missions – there you will find the Diocesan Museum of Jesuit Guarani Art, where you can appreciate sculptures made of polychrome wood carved by the Guarani.

A visit to the ruins of San Cosme y Damián, located in Itapúa (Paraguay's southern region Department), offers up the chance to witness a vibrant scientific history. There you can find an early 17th-century rustic telescope, astronomical quadrants, and a sundial (still preserved in the property's patio) built to observe the stars. In addition, the Buenaventura Suárez Astronomical Interpretation Center is located there, which has many attractions for both children and adults interested in astronomy.

Figure 4. The night tour of the Guarani Jesuit Mission.

Other points included in the Jesuit Route of Paraguay are the ruins of the Missions of Jesus de Tavarangue, our Lady of the Incarnation, Santa Rosa de Lima, and many others.

This route is an unforgettable adventure filled with history, culture, art, and natural beauty. The night tour of the Guarani Jesuit Mission is definitely worth including in your visit. ***(Figures 4, 5)***. For more information about these places and the possible routes available, you can visit the site of the National Secretariat of Tourism of Paraguay (**www.senatur.gov.py**), or take a virtual tour of the route and all its history by visiting **www.caminodelosjesuitas.com**.

Figure 5. The night tour of the Guarani Jesuit Mission.

ISAPS GOURMET

MARCELO MAINO, MD – BRAZIL
ISAPS Assistant National Secretary

THE BRAZILIAN CHURRASCO

Barbecues are one of the most universal types of food. All around the globe, people get together to prepare them, and come together to enjoy them. What sets each barbecue apart from one another is the way in which it is made and the traditions which revolve around it. The Brazilian barbecue, called **"Churrasco"**, is a ritual of enjoying the companionship of family and friends as all gather around the barbecue grill, waiting for the delicious dish to be ready. In our country, churrasco goes way beyond being just a meal – it is an event, a celebration of our culture, and the people we care about.

Historically, it was in the 17th century in Rio Grande do Sul, that the Gaucho way of barbecuing originated. The discovery of the churrasco is attributed to the indigenous people who inhabited our region. They roasted meat outdoors, on a bonfire over rocks with the help of a wooden grill, but it was in the Pampas region where the churrasco found its ideal environment. Because of this, Rio Grande do Sul celebrates the churrasco as one of the most important parts of its culinary patrimony. Moreover, it has spread throughout the country and is recognized and appreciated internationally.

What distinguishes our barbecue is the way that we prepare it. First of all, **choosing the right meat is essential**, the most popular types of meat to eat in the churrasco being the "vazio", "picanha", and ribs. Besides their fantastic taste, they can serve a larger number of people, which is necessary as the barbecue is seldom a two-person meal. Following that step, you have to pay attention to the fire. After putting the charcoal in the **"Churrasqueira"**, you should only start putting the meat in once the fire is in the "brasa" stage (when the flames have gone). It is also worth noting that the only seasoning we usually use is coarse salt.

Moving on to roasting the meat, you can use skewers or grills. The process is to grill the meat briefly on one side, then turn it over, adding the coarse salt at this stage (**a lot**, really!). Repeat the process for the other side and just wait for the meat to be ready and succulent!

Figures 1, 2. The photos speak for themselves – need I say more?

When it comes to serving, our custom is to cut the meat into small-sized pieces as this encourages people to appreciate the meal, and the company around them, for a longer period ***(Figures 1, 2)***.

One last thing to remember: a sharp knife is a very important part of your cutlery arsenal – every Gaucho who cooks barbecue meat is proud of owning a great knife!

ISAPS TRAVEL

ANEESH SURESH, MS – INDIA

HAMPI: INDIA'S LOST KINGDOM

Hampi, located in the southern state of Karnataka, India, has been rightly bestowed with the prestigious status of a UNESCO World Heritage Site. It feels surreal when visiting this vast landscape, strewn with boulders, azure skies, verdant fields, royal pavilions, and bastions, almost as if you were entering another universe.

It was the former capital of the once-powerful Vijayanagara empire in the 14–17th centuries. Owing to its immense prosperity, and decline in power, the kingdom was plundered by the rival armies of the Deccan Sultanate, turning it into rubble and ruins. Notwithstanding this, the rich history emanates through the remains of the austere Indo-Persian architecture, transporting you to the erstwhile bustling Vijayanagar empire.

The Tungabhadra River meanders through the town of Hampi, creating an oasis amid this vast craggy landscape ***(Figure 1)***. You can wander through the rugged terrain and be immersed in the architectural marvel of the monuments,

Figure 1. Tungabhadra River.

ride a coracle across the river, or treat yourself to a bird's-eye view with a short hike to the nearby hilltops ***(Figure 2)***.

The fantastical temples and monuments cling to Hampi's folklore. The highlight amongst them is the magnificent Vittala temple with its musical pillars and giant stone chariot,

Figure 2. View from Matanga Hill.

rewarded with its own motif on the new Indian 50-rupee currency notes ***(Figure 3)***.

Figure 3. Giant stone chariot.

Hampi displays a potpourri of cultures and traditions, with innumerable temples and mosques standing together in perfect harmony. After your eyes have devoured the beauty of the landscape, do not miss the chance to witness the ever-changing colors of the sky during sunset ***(Figure 4)***.

Figure 4. Vibrant sunset colors.

As the light fades and the monument complex closes its doors, the bazaar springs to life. Enjoy a stroll along the banks under the waning twilight, indulge yourself in the local street food, or strike a conversation with the local artisans ***(Figure 5)***. Before you call it a day, and seek the comfort of your cozy bed, spend some time stargazing. Away from the ever-growing city light pollution, Hampi is one of the best spots in the country for astrophotography.

Figure 5. "Blue hour" along Tungabhadra riverbank.

When visiting India, do travel to Hampi and experience the magical feeling – this place has something for everyone. The best time to visit would be November through to January: the summers are not too hot, the nights are pleasant, and the town comes to life for the Hampi Utsav or Vijaya Utsav, a three-day extravaganza with cultural shows, fireworks, and exhibitions celebrating its rich history and grandeur. Hampi is well connected with India's major cities and towns via a strong network of trains, buses, and flights. The nearest railway station is Hospet, 15 km away, and the closest airport is Vidyanagar, around 40 km away, with connecting flights from Bangalore and Hyderabad.

ORCHHA: A "HIDDEN" CAPITAL OF THE BYGONE ERA OF BUNDELKHAND

SAMARTH GUPTA, MS – INDIA

It is not new for anyone to be held captive within their own thoughts when thinking about the much-treasured mystic royalty of India, from the timeless charm of the Rajput Dynasty's Maharajas to the ferocious Marathas, comprising of the Scindias, Holkars, Gaikwads of the vast Indian empire; everyone has been in awe of their rich culture, heritage, and imperishable legacy.

Indians are truly blessed to witness a plethora of palaces and fortresses across the length and breadth of our nation as a rich remembrance of their legacy bestowed upon us. However, since India is also known for its multicultural and multifaceted geography as well as ethnicity, it comes as no surprise to me when one gets baffled to acknowledge the valor and pride of Bundelkhand's bygone era. Bundelkhand is a region nestled amidst majestic fortresses and rivers in the center of India, in the state of Madhya Pradesh. I feel even the most voracious travel aficionados of India would have easily skipped the associated history and legacy behind the Bundel warriors and their rich heritage.

Well, no surprise to anyone that Indian weddings are a mega affair for us Indians – an integral part of our culture, and something we enjoy thoroughly. Thus, in the autumn month of September 2021, my family and I headed to my mother's ancestral region of Bundelkhand for my cousin's wedding, arranged in Orchha, a quaint and beautiful cobbled town about which I had barely heard before.

In central India, travelers from across the globe witness the Nagara-style architectural symbolism and erotic sculptures of the Khajuraho group of Hindu and Jain temples but, about 175 kms from this UNESCO World Heritage Site, lies Orchha which derived its name from the phrase "Urchha" translated as "hidden", an undiscovered territory, which Raja Rudra Pratap Singh unraveled and shaped into his capital in the 16th century. Once considered the most powerful and influential kingdom of its time, the rulers of which prevented the Mughals from capturing the rest of this region, Orchha today remains largely the same since its strong foundation. There is a medieval aura that takes you into a transcendental universe that reflects the glory of its kingdom.

Figure 1. Chaturbhuj Temple's splendid spherical spires 350 feet above ground level.

Orchha, which only recently appeared in the lens of Indian tourism, is a living cultural site where new development still lies in the shadows of its historical monuments, gardens, temples, and murals as an ensemble, representing remarkable evolution in town planning, fortification of settlement, buildings, garden design, and art. No-one can escape goosebumps when strolling around this town wondering about the Fort Complex, consisting of the Jehangir Palace (built for Emperor Jehangir), the Chattris, the Chaturbhuj Temple ***(Figures 1, 2)***, and the Raja Ram Temple. The Chaturbhuj

Figure 2. View of the Orchha Fort complex from Chaturbhuj Temple.

Figure 3. Sadly, Jehangir Palace's architecture did not impress Emperor Jehangir; it led to war between the Orchha King and Mughal Emperor.

Temple is a Vedic Hindu temple that gives an impression of a cathedral, towering 350 feet into the air, a mark that subtly leaves its footprints on your soul. Accompanying us was a local travel guide who painted a remarkable canvas of Orchha's 500-year-old history while fostering various traditions of myths, literature, and art. The Jehangir Palace is a fantastic blend of Indo-Islamic architecture style ***(Figures 3, 4)*** amidst the Bundel influence, which cannot go unnoticed by an experienced eye, something that you will not find in the rest of the country.

In popular culture, many would have heard of the famous Mastani, wife of the Maratha emperor Peshwa Baji Rao I, who also happens to be the daughter of the Bundel king Maharaja Chhatrasal Bundela, who sought help from the Peshwa to save his kingdom and his valiant race from the point of extinction from the Mughal invaders.

Figure 4. The ceilings are covered with frescoes depicting the incarnations of Lord Vishnu.

While on the tour one evening, we decided to walk down the banks of the River Betwa, only a 10-minute walk from downtown. We found an exciting opportunity to kayak along the historic riverfront, filling our eyes with glee and awe ***(Figure 5)***. If you are an avid paddler and enjoy architecture, this short 5-km adventure is sure to leave you spellbound while witnessing the magnificence of the enormous chhatris, temples, and fortress along the banks of the Betwa River – truly a unique exemplary experience on its own.

Figure 5. Kayaking in a picturesque frame of the Chhatris from the River Betwa.

Orchha is a prime example of small places that lure you into their own culture, heritage, and stories of unsung heroes. They provide value because you go with little expectation, only to be swept away by what they offer. I strongly believe Orchha is nothing less than Mozart's unheard symphony.

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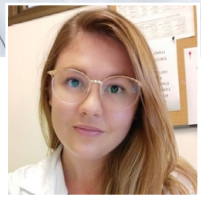

MARIA G. CEI – ARGENTINA

OUR APPROACH TO FACIAL OPTIMIZATION IN THE MASSIVE WEIGHT LOSS PATIENT

According to the 2019 World Health Organization census, 67% of adults in Argentina are overweight or obese[1]. Hence, bariatric and post-bariatric surgeries are increasing in frequency, reflected in the increase of surgical practices for plastic surgery residents. In general, massive weight loss (MWL) surgery patients have a great amount of redundant skin and an accelerated appearance of facial aging, due to thinning of the fatty layer beneath the skin[2]. In the MWL patient, the characteristic findings in the upper third of the face is temporal hollowing and prominence of the lateral orbital rim, alongside other age-related changes[3].

Due to falling bed numbers during the COVID-19 pandemic, plastic surgeries were limited to short duration, short hospital stay or outpatient surgeries. At the Plastic Surgery Service, Parque de la Salud, the therapeutic approach to the post-bariatric patient is focused on several staggered procedures: we first address lower and upper body contour, then limbs, and ultimately facial and cervical laxity. MWL facelift requires extended incisions and incision placement along the hairline. The ideal frontal hairline in women is approximately 5–6 cm from the brow at the pupil, and 6–7 cm in men[4]. We present a 60-year-old female patient who underwent a sleeve gastrectomy in 2017 and lost 54.4 kg.

Figure 1. Preoperative iconography of a patient depicting brow ptosis, a glabella-to-hairy-anterior-line distance higher than 6 cm, facial skin redundancy and laxity.

As a result, she had ptosis of the eyebrow tail, a glabella-to-hairy-anterior-line distance higher than 6 cm, orbital hollowness and palpebral ptosis, and facial skin redundancy and laxity ***(Figure 1)***. The patient was marked in a seated

Figure 2. Preoperative markings.

Figure 3. W-shaped prepilose incision.

upright position ***(Figure 2)***. Through a W-shaped prepilose incision, the frontal, temporal, orbital rims, and glabellar regions were addressed up to the zygomatic arches in a subcutaneous plane of dissection ***(Figure 3)***. Procerus and corrugators muscles were identified and treated. The adipose-cutaneous excess was removed, correcting the brow ptosis and avoiding the necessity of an upper blepharoplasty. Auersvald sutures were placed in the forehead. Through a subciliary incision in the lower eyelid, the excess of orbicularis oculi muscles was resected and pexed to the periosteum of the lateral orbital rim, 1 cm below the tendon of the lateral canthus.

Figure 4. Three-month post-operative results.

In the post-operative control at three months, we can appreciate the correction of the cutaneous redundancy and erasure of wrinkles in the frontal region, maintaining the facial aesthetics units and a correct distance between the glabella and anterior hairline ***(Figures 4, 5).***

In conclusion, facial changes of patients with MWL mimic age-related findings observed in the non-MWL population. Bariatric and post-bariatric plastic surgery continues to surge in Argentina. MWL patients are complex surgical patients that can be successfully treated, customizing staged procedures yielding faster recovery, better results, and lower complication rates. This technique is a feasible procedure for resident surgeons, with a shorter learning curve and reproducible results.

Figure 5. Incision close-up.

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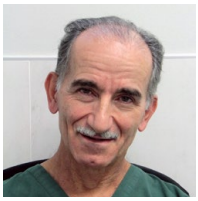
IN MEMORIAM

DR. PIETRO BELLINVIA, MD (1945–2021)



DR. PIETRO BELLINVIA
written by Dr. Gianluca Campiglio, MD

On June 15, 2021, Dr. Pietro Bellinvia, one of our distinguished Italian ISAPS members, passed away. He was born in Lecce, a beautiful city in the south of Italy, and then moved to Milan.

While in Milan, Dr. Bellinvia graduated cum laude in medicine. He became a specialist in head and neck surgery at the University of Pavia and then decided to complete his training, as well as concluding his residency in plastic surgery, at the University of Milan.

He worked for many years in the public healthcare system while simultaneously building up a very successful private practice in aesthetic surgery. His main field of interest was the face and, in particular, rhinoplasty. His skills and knowledge as an ENT and plastic surgeon enabled him to face any kind of problem related to the function and aesthetics of the nose. He was curious and open to new approaches and techniques in plastic surgery.

Dr. Bellinvia is survived by his adorable wife Olga and his three children Monica, Carlo, and Giacomo. Monica is a dermatologist, Carlo a dentist, and Giacomo is a plastic surgeon who will continue his father's legacy and activities in Milan, thanks to the solid foundation of his father's teachings.

IN MEMORIAM

DR. MICHAEL SCHEFLAN, MD (1945–2022)

DR. MICHAEL SCHEFLAN
written by Dr. Yoram Wolf, MD

Our ISAPS family and plastic surgeons around the world are mourning the loss of Dr. Michael "Mickey" Scheflan, an Israeli global leader in our profession, who passed away on February 12, 2022.

Dr. Scheflan was born on June 4, 1945. After attending medical school in Switzerland, Dr. Scheflan graduated from the Tel Aviv University Medical School. He then underwent general surgery training in New York at the Albert Einstein and Mount Sinai University and Harvard University in Boston, and, following on from there, completed his plastic surgery training at Emory University in Atlanta.

Dr. Michael Scheflan was board certified by the American Boards of Surgery and Plastic Surgery and by the Israeli Medical Association Scientific Board. He practiced in Tel Aviv and his main fields of interest were aesthetic and reconstructive breast surgery, facial rejuvenation and body contouring (both of these through surgical and non-invasive techniques), and the clinical use of adipose-derived stem cells. He was the author of numerous scientific articles and book chapters in plastic and reconstructive surgery on topics ranging from breast reconstruction, acellular dermal matrix and tissue reinforcement, breast aesthetics, breast implants, fat grafting, body contouring, facial rejuvenation, and more.

Dr. Scheflan was Past President of the Israel Society of Plastic and Aesthetic Surgery and the Mediterranean Society of Plastic Surgeons, and past ISAPS National Secretary for Israel. He was a member of ASPS, The Aesthetic Society, ISAPS, IPRAS, and IMCAS, and served as an international editor for the *Aesthetic Surgery Journal*. He was a recognized worldwide guru of plastic surgery with vast global teaching experience in aesthetic medicine ***(Figures 1, 2)***.

Dr. Scheflan is the recipient of several prestigious awards, namely the James Barrett Brown Award (AAPS) for being the co-developer of the TRAM Flap, the Carl Moyer Award (ABA), the Raymond Villan Award (ASAPS), and the 2012 Malliniac Lecture Award (ASPS).

Figures 1, 2. "Mickey"'s notable professional passion was teaching.

In the words of a few of Dr. Scheflan's colleagues...

"His reputation as an international ambassador for the specialty, and a true pioneer, helped open doors for future generations of plastic surgeons in Israel. He was a teacher and mentor for many students, residents, and specialists."
Dr. Yoav Barnea, MD

"He was unique in that he truly was an international force in plastic surgery. He forged tight bonds everywhere he went."
Dr. Jack Fisher, MD

"Mickey will be dearly missed in the plastic surgery community and beyond. What a beautiful human being he was; a source of inspiration for all of us."
Dr. Alexis Verpaele, MD

"For years Michael was an international metonym for Israeli plastic surgery."
Dr. Alan Matarasso, MD

"What I remember most about Michael was his insatiable curiosity for innovations in plastic surgery. He was, is, and will always be a pioneer of plastic surgery. He was bright and innovative as a resident and throughout his illustrious career."
Dr. Foad Nahai, MD

"I think he was a man of superior intelligence, a great innovative surgeon, and an excellent teacher."
Dr. Giovanni Botti, MD

"He was a consummate researcher and innovator. His legacy will live with us."
Dr. Oscar Ramirez, MD

"Michael was a wonderful colleague and dear friend. He made numerous contributions to our missed."
Dr. J. Peter Rubin, MD

"He was a great leader and very nice person."
Dr. Nazim Cerkes, MD, PhD

"We all lost an outstanding master, a brilliant mentor – one of the giants in plastic surgery on whose shoulders we all stand – but, most importantly, we lost a friend."
Dr. Kai Schlaudraff, MD

"Mickey", as we all knew him, was in his prime when he was abruptly taken away from us. He still had so much more to contribute to his fellow plastic surgery colleagues and students around the world. He will be cherished in our memories and his legacy will accompany us in the future.

May he rest in peace.

ISAPS Welcomes New Members

January – March 2022

You can find all degrees of the new members in the membership directory at: https://www.isaps.org/member-directory

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MEETINGS CALENDAR

ISAPS® Webinar

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

ISAPS COURSE – THAILAND
Dates: March 14–16, 2022
Location: Phuket, Thailand
Venue: Marriott Resort & Spa, Merlin Beach
Contact: The Society of Aesthetic Plastic Surgeons of Thailand
Email: isapsthailand2022@gmail.com
Website: isapsthailand2022.com

ISAPS ENDORSED – ONE-DAY PROGRAM ON MINIMAL INVASIVE AESTHETIC SURGERY (during AMWC 2022)
Dates: March 31–April 2, 2022
Location: Monte-Carlo, Monaco
Venue: Grimaldi Forum, Monte-Carlo
Email: Contact Us (euromedicom.com)
Telephone: +33 (0)1 58 56 74 00
Website: www.euromedicom.com/amwc-2022/

ISAPS ENDORSED – EASAPS BIENNIAL MEETING: BREAST SURGERY AND BODY CONTOURING
Dates: March 31–April 2, 2022
Location: Lisbon, Portugal
Venue: Marriott Hotel
Email: info@easaps.org
Telephone: +39 02 66802323
Website: EASAPS Biennial Meeting – Easaps

ISAPS MINI SYMPOSIUM (during THE AESTHETIC MEETING 2022)
Dates: April 22, 2022 *(full meeting: April 20–24)*
Location: San Diego, CA, USA
Venue: San Diego Convention Center
Contact: Victoria Cierpich
Email: victoria@theaestheticsociety.org
admin@theaestheticsociety.org
Website: meetings.theaestheticsociety.org
ISAPS program: Click here

ISAPS SYMPOSIUM – 2ND ISAPS DAYS IN BELGRADE
Dates: May 27–28, 2022
Location: Belgrade, Serbia
Venue: Hilton Hotel
Email: belgrade@isapsdays.com
Website: isapsdays.com/en

ISAPS ENDORSED – SOFCEP CONGRESS
Dates: June 2–4, 2022
Location: Toulouse, France
Venue: Pierre Baudis Congress Center
Contact: Marie Christol-Souviron
Email: sofcep@vous-et-nous.com
Telephone: +33 (0)5 34 31 01 34
Website: www.chirurgiens-esthetiques-plasticiens.com

ISAPS ENDORSED – IMCAS LIVE AESTHETIC SURGERY COURSE 2022
Dates: June 3–5, 2022
Location: Paris, France
Venue: Palais des Congrès
Email: contact@imcas.com
Telephone: +33 (0) 1 40 73 82 82
Website: www.imcas.com

ISAPS SYMPOSIUM – 18TH CONGRESS OF POLISH SOCIETY OF PLASTIC, RECONSTRUCTIVE AND AESTHETIC SURGERY
Dates: June 8–11, 2022
Location: Szczecin, Poland
Venue: Radisson Blu Hotel
Contact: Polish Society of Plastic, Reconstructive and Aesthetic Surgery
Email: biuro@ptchprie.pl
Website: www.ptchprie.pl

ISAPS SYMPOSIUM – 18TH INTERNATIONAL BEAULI
Dates: June 10–11, 2022
Location: Berlin, Germany
Venue: NH Collection Berlin Mitte Friedrichstrasse
Email: bbusch@bb-mc.com
Telephone: +49 89 189046133
Website: www.beauli.de

ISAPS COURSE – 5TH MARBELLA INTERNATIONAL PLASTIC SURGERY SUMMER SCHOOL
Dates: June 16–18, 2022
Location: Marbella, Spain
Venue: Hotel Barcelo Marbella
Contact: Vanessa Garcia
Email: info@mipss.eu
Tel: +34 95 177 5518
Website: www.mipss.eu

ISAPS ENDORSED – IGUAZU AESTHETIC MEETING 2022: FACIAL AND BODY CONTOURING SURGERY

Dates: June 23–25, 2022
Location: Puerto Iguazu-Misiones, Argentina
Venue: Mercure Iguazu Hotel IRU, Calle Selva Iryapu S/N – 600 HAS. Puerto Iguazu-Misiones Argentina
Contact: Gustavo Abrile
Email: gustavoabrile@gmail.com
Telephone: +54 3764 693461
Website: iguazuaestheticmeeting2022.com.ar

ISAPS SYMPOSIUM – 15TH INTERNATIONAL CAUCASIAN CONGRESS ON PLASTIC SURGERY AND DERMATOLOGY KOLKHIDA

Dates: July 1–3, 2022
Location: Tbilisi, Georgia
Venue: Biltmore Hotel Tbilisi
Email: hello@kolkhida.org
Telephone: +995 32 2920371

ISAPS ENDORSED – SOAP MEETING 2022

Dates: July 14–16, 2022
Location: Bremen, Germany
Venue: Dorint Park Hotel
Contact: Jens Kramer
Email: jens_kramer@logi-vent.de
Telephone: +49 4241 933260
Website: www.soap-meeting-bremen.de

ISAPS ENDORSED – INDIE AESTHETIC SURGERY SUMMIT

Dates: August 28–29, 2022
Location: Virtual
Email: drr@drrosenfield.com or jeffrey.marcus@duke.edu
Telephone: +1 650 692 0467
Website: indieaestheticsurgerysummit.com

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