Experts from around the globe will gather in New York City for the 8th International Symposium of Facial Plastic Surgery from May 1st to the 5th of 2002. This colossal educational experience will be comprehensive, contemporary, and collaborative.

Symposium chair, J. Regan Thomas, MD, and program chair, Michael J. Sullivan, MD, have secured lecturers who are masters in their respective fields. International societies as well as other related medical specialty societies will be presenting methods, techniques, and technology from their unique perspectives.

M. Eugene Tardy, Jr., MD, of Oak Park, Ill., will speak as the honored guest on *A Rhinoplasty Odyssey: Vital Lessons from Long-Term Outcomes*, May 2, Thursday morning. As an acclaimed rhinoplasty surgeon, Dr. Tardy has spent the past 40 years actively involved in promoting and ensuring the future of facial plastic surgery. Trained in Chicago, Dr. Tardy began a private practice and taught part-time at the University of Illinois. Since then he has served as president of the American Academy of Otolaryngology-Head & Neck Surgery (AAO-HNS) and the AAFPRS, along with many other appointments at these organizations and others, such as the AMA, ACS, and ABO. Dr. Tardy’s commitment to education is reflected in the numerous courses he has taught worldwide, including Johns Hopkins, University of Guadalajara, Mayo Clinic, University of Rotterdam, Indiana University, University of Verona, University of Wisconsin, University of Washington, University of Homburg, Stanford University, Rush Medical School, University of North Carolina, Ohio State University, and University of Wiener.

Honored guest, Robert L. Simons, MD, of Key Biscayne, Fla., will address attendees with a talk entitled *Our Love is Here to Stay*. The content of this lecture is based on Dr. Simons’ many dedicated years working on behalf of facial plastic surgery. Dr. Simons was president of the AAFPRS, and is credited with the following contributions to the Academy: devised the *John Conley Lectureship*; organized the Founder’s Club and Past President’s Club; was a representative to the AAO-HNS Board of Governors and ACS Advisory Council of Otolaryngology; developed *Facial Plastic Times*; edited the AAFPRS history book *Coming of Age*; and served as southern regional vice president, national program chairman, and treasurer. He has a busy private practice, fellowship program, and many teaching engagements. Instrumental in the formation of the American Board of Facial Plastic and Reconstructive Surgery (ABFPRS), of which he was president from 1991 to 1994, Dr. Simons continues to stay involved in support of its growth. The Academy has honored Dr. Simons with the F. Mark Rafaty Memorial Award, the Larry Schoenrock Memorial Award, and the Founder’s Club Lifetime Achievement Award. His zealous work during the past five decades will emanate through his address to the symposium attendees Friday afternoon.

Keynote speaker, Nancy L. Snyderman, MD, is a board certified surgeon of otolaryngology and a trained pediatrician. She is well known for her medical reporting on *Good Morning America* and will be aptly presenting *Medicine and the Media* Thursday afternoon. She has published numerous articles in *Facial Plastic Times*. See Participation of Other Societies, page 8
When You Are Faced

I recently saw a 35 year-old woman who requested that I evaluate a scar on her upper lip. She also complained of slight asymmetry and deviation of her nasal tip. She gave a history of a previous rhinoplasty performed several years earlier. Although the scar on the lip was deforming, it was the slight asymmetry and subtle deviation of the nasal tip that was her primary concern. The patient gave a history of being seropositive to hepatitis C although she was asymptomatic. Similar to HIV, the virus causing hepatitis C is either transmitted sexually or blood-borne. Approximately 75 percent of individuals infected with the virus go on to develop a chronic, progressive hepatitis. There is no vaccine currently available for this disease.

This case prompted me to question whether I was ethically and legally required to accommodate the patient’s desire to have a revision rhinoplasty and scar revision. The risk of infecting myself or other medical staff with hepatitis C using universal body fluid precautions is very small. However, if it were to occur, the consequences are dire. Is it justified to expose several medical personnel (surgeon, resident, fellow, scrub nurse) to the risk of infection when the procedures in question are not only elective, but cosmetic in nature? Did I have a duty to operate?

What are the ethical and legal requirements of a facial plastic surgeon with regard to aesthetic surgery? Are there laws governing the right of patients to have cosmetic surgery and what are the ethical grounds for denying such surgery to patients?

The physician’s code of ethics has varied over the centuries. For instance, during the middle ages many doctors fled towns and cities affected by the bubonic plague, while others stayed behind at great personal risk, presumably because of a sense of professional obligation. In the era of yellow fever, the newly promulgated American Medical Association (AMA) code of ethics described an obligation to treat patients in the midst of an epidemic regardless of the danger to the individual physician. More recently, in 1994, the AMA council on ethical and judicial affairs published guidelines which state that physicians are free to choose whom they will serve, however, the physician should respond to the best of his or her ability in cases of emergency where first aid treatment is essential. Once having accepted a patient for care, the physician should not neglect the patient, nor withdraw from the case without giving notice to the patient, the relatives, or responsible friends, sufficiently in advance of withdrawal to permit securing another medical attendant. The AMA code of ethics also notes that a physician may not ethically refuse to treat a patient whose condition is within the physician’s current realm of competence solely because the patient is seropositive for a communicable disease. I certainly could not say this case was beyond the scope of my skills.

Where did I stand legally? Individual physicians have a moral obligation to care for the sick. The prevailing legal and AMA guidelines make it clear that physicians do not have to accede to whatever procedure a patient requests, and this refusal by the physician does not have to be based solely on whether it will benefit the patient. The law characterizes the doctor-patient relationship as a contract between autonomous individuals who are at liberty to break off the contract provided that the patient is not abandoned. In addition, in the absence of an agreement to provide medical care, there is no doctor-patient relation-
ship. However, the legal right to decline to care for patients is limited. Employment contracts, as with hospital or health maintenance organizations, may oblige facial plastic surgeons to care for qualified individuals who seek treatment. Physicians who are on-call for a hospital may be required as a condition of staff privileges to provide care to anyone who presents there. Anti-discrimination laws may also limit the surgeon’s right to decline to care for patients on the basis of race, sex, national origin, religion, or disability. The Americans with Disabilities Act of 1990 states that individuals shall not be discriminated against on the basis of disability in the full and equal services of a hospital or physician’s office. Patients with HIV or hepatitis C infections as well as those with other infectious diseases are specifically included under the law.

I consulted with an attorney in the legal office representing the University of Michigan Medical School and Hospital. There have been two notable lawsuits under the Americans with Disabilities Act that deal with citizens that were seropositive to HIV. A teacher in grade school was fired because of being HIV positive. The teacher subsequently sued the school system and the Supreme Court ruled for the teacher, saying that the teacher was discriminated against.

The second case involved a dentist who was asked by an HIV positive patient to perform necessary dental work. The dentist demanded the work be performed in a hospital under greater sterile conditions. This would have significantly increased the cost to the patient. The patient sued the dentist and won because the courts found that he had been discriminated against based on his health record. According to federal regulations designed to implement the Americans with Disabilities Act, physicians are not required to provide care when an “individual poses a direct threat to the health or safety of others that cannot be eliminated or reduced by reasonable accommodation.” It is likely that the courts will interpret “direct threat” to mean a significant risk of substantial harm, not merely a slight risk. Although the courts have not yet ruled on whether caring for HIV infected persons poses a “direct threat” to healthcare workers, it is unlikely that this and other similar blood-born infectious diseases will be considered a significant risk.

My dilemma was whether I should consider the patient’s history of hepatitis C in my decision-making concerning whether to perform surgery. My choices appeared to be as follows: 1) I could refuse to accept this person as my patient and thus avoid the dilemma altogether. The decision would have been motivated by the slight risk of infecting myself or other medical staff with the hepatitis C virus. The patient could in turn say that this was discriminatory; 2) I could agree to revise the facial scar, but not the nose because the risk of infecting myself or medical staff is less for the scar revision and much greater for the rhinoplasty. This assumption is based on the duration and the number of surgical instruments used for each procedure and the degree of exposure to the patients blood; 3) I could agree to perform both surgical procedures; 4) I could completely disregard the fact that she was seropositive to hepatitis C and make my decision strictly on the physical findings at hand.

According to my legal counsel, the second option appeared to be more sustainable than the first from a legal perspective since the scar was unsightly and probably affecting quality of life more than the nasal deformity. The patient could argue, however, that being seropositive to hepatitis C is a disability and based on this she should not be treated differently than other patients seeking cosmetic surgery. In addition, she was more concerned about the appearance of her nose and saw this as a more important factor in her quality of life than the scar.

The law requires that a physician care for all patients alike that require necessary medical treatment, but there is no statement concerning unnecessary (cosmetic) surgery. It is important for the facial plastic surgeon to remember that medically necessary services can be elective.

See The Risks We Take, page 4
THE RISKS WE TAKE

From President's Message, page 3 point the decision would tip in favor of not treating? From an ethical point of view, the fourth option of not allowing the fact that the patient was seropositive to hepatitis C influence my decision to operate probably represents the moral high ground. It places the decision to operate directly on the likelihood of improving the appearance of the lip and the nose compared to the risk of not improving the appearance or even making the condition worse. I believe that facial plastic surgeons should be willing to perform invasive procedures in the face of the risk of contracting a blood-born infectious disease if the medical benefit to the patient is clearly established, highly probable, and substantial. However, the risk benefit ratio must be considered. If the benefits of surgery are unproved, uncertain, or marginal, the safety of the surgeon and the medical staff should be given more weight in deciding to operate.

As surgeons, we are morally obligated to treat the sick and injured with competence and compassion and without prejudice. We should be willing to apply our knowledge and skills when needed, though doing so may put us at risk. We should also concede our human fears and limitations so that reflection, honest discussion, and constructive action is possible. The fear of contracting a fatal disease should be acknowledged as an understandable human reaction, not condemned as unjustified. Surgeons may feel uncomfortable discussing negative reactions to certain patients. However, it is helpful to express our feelings of apprehension and anxiety and to have them validated in a non-judgmental setting.

Shan R. Baker, MD

MESSAGE FROM THE MEDICAL EDITOR

MAKE YOUR OPINION COUNT

By David Reiter, MD, DMD

“Diamonds are nothing more than lumps of coal that stuck to their jobs,” says Malcolm Forbes. And while I hadn't planned on hanging around quite that long, the principle does apply to us as well. I'm seeing a fairly large number of patients for second opinions who were pressured by their facial plastic surgeons to have far more than they wanted.

One lovely 20-year old wanted a rhinoplasty because she has a small dorsal hump and a severe caudal septal deflection from a childhood injury. She’s an athlete who stands about 5’2” and weighs no more than 105 pounds, but was told she really needed submental liposuction despite a classic jawline and a fine-looking neck. She and her mother thought that the doctor who said that was nuts.

I'm seeing more and more patients with a single reasonable concern but a laundry list of recommendations from other doctors. These people are pretty upset with us. They think we're selling surgery without regard for their welfare. Sometimes it seems that they're right.

It's good to make an honest recommendation for additional procedures to complement the patient's primary desire. The line between doing that and padding the bill, however, is sometimes pretty thin. I've had patients tell me of a doctor's insistence that lip augmentation would make the nose look smaller and should be done with every rhinoplasty. A member of our women’s board told me last week that she was told by another doctor to have laser treatments to reduce the pinkness in her cheeks. She wanted to know if I’d do it for her. She’s got a hint of pink in her cheeks, and she looks great—not one single ectatic vessel, very smooth skin surface—a pretty woman with bloom in her cheeks.

Are you running a sprint or a marathon? The sprinter takes off like a shot and consumes a lot of energy trying to beat the others to a finish line that’s not that far away. Most sprinters can’t get very far beyond the immediate goal. They have one technique, one focus, one course of action. And there’s only one winner in every race. Sprinting doesn’t do much for one’s cardiovascular fitness, yet you have to be in great shape to do it. It involves short-term goals and when it’s over, it’s over.

Distance runners can handle a setback. They know that strategy and preparedness will help them keep going. They also know that inch-by-inch position is not that important, and that the eventual winner may seem to lag behind the field before catching those who shot their wads early. They also focus as much on personal best and individual achievement as they do on an outright victory. Only one person can win and the field is large. But it seems that a far greater proportion of marathoners are happy and satisfied after their race than is true of sprinters.

We provide health care. We take a history, examine the patient, and make recommendations based on our knowledge, judgment, and experience. We don't have to operate on every patient who comes to us. We do have to give each person the best advice we can. In the long run, those who do will prevail—like the lump of coal that did its job. It may take a few years, but patients who got better advice from you but went with the other opinion will find this out at some point—and they’ll remember you. Try hard to avoid getting that “I told you so” look when they come back. It’s always been difficult for me. And they send their friends.
Now that 2002 is well under way, we've decided to reflect upon where we've been and where we are headed in our public relations endeavors. Below is a recap of Magnet Communications’ public relations results for the Academy in 2001, along with a sneak peak of what's to come.

Magnet is excited to report that from January 2001 to December 2001, public relations efforts for the AAFPRS generated a total viewership/circulation/Internet hits of nearly 215 million media impressions—which has more than doubled (110 percent!) since the same time period in 2000. This success was influenced by a number of new initiatives, as well as the high-quality, in-depth features that helped to promote the Academy and its services.

For example, Magnet worked with an outside service to conduct a national omnibus survey that asked 700 employed adults about their thoughts on aging and how it affects them in the workplace. Based on the surrounding media outreach for the survey, results were featured in several syndicated columns, which generated placements in various local morning news segments and in national newspapers (including Chicago Sun-Times, Indianapolis Star, Sacramento Bee and Arizona Republic). Additionally, pitching efforts also resulted in magazine placements (such as Working Mother and Today’s Chicago Woman), as well as full-feature newspaper stories.

As part of the omnibus survey, 500 men were asked about their grooming regime, which helped in the development of a targeted men’s pitch. From this outreach effort, the AAFPRS was spotlighted in Los Angeles Times Magazine, New York Post, Woman’s Own, Jacksonville Magazine and News Press (FL), just to name a few.

As in previous years, Magnet leveraged the results from the annual membership survey to generate placements in various news outlets. However, this year, Magnet consulted the AAFPRS regarding how to enhance the survey and make both the information and the final report more presentable and media-friendly.

Based on Magnet’s ongoing conversations with the media, they were able to provide valuable input as to the kind of information that journalists seek. Magnet advised the AAFPRS to add several new questions to the survey, including a question about medical tourism, which was spotlighted in Joan Kron’s “Scalpel News” column (Allure magazine). This placement was also a direct result of the New York Media Tour, in which Russell W.H. Kridel, MD and Ira D. Papel, MD, presented Ms. Kron with the information in person.

Another noteworthy success last year was the coverage for the AAFPRS FACE TO FACE: The National Domestic Violence Project. In June, She-TV (Discovery Health Channel) aired a segment that focused on domestic violence. The piece featured patients who had undergone surgery to through the FACE TO FACE program. In October, Self magazine included a two-page feature article on the program, and shared the story of a woman who was a patient of Andrew Frankel, MD. Both placements also included the AAFPRS domestic violence toll-free number so that women could call the helpline for further information.

In 2002, the AAFPRS will be featured in magazines such as Elle and Details—both will include the results of the AAFPRS celebrity membership survey. In addition, the Academy plans to release its 2001 statistics on facial plastic surgery trends to the media this summer. With the growing popularity of cosmetic surgery, we expect a lot of interest from the media.

On March 20th, another in-depth documentary about domestic violence and the FACE TO FACE program will air on the Discovery Health Channel.

More creative omnibus surveys and many targeted pitches are in the works for this year.
IN BRIEF: MEMBER APPOINTMENTS

Daniel G. Danahey, MD, PhD of Chicago, was appointed assistant professor of otolaryngology of the Northwestern University of Medical School.

Kriston J. Kent, MD of Naples, Fla., spoke at a conference at Wake University School of Medicine regarding office-based surgery. The conference was supported by the National Institutes of Health (NIH) to share specific advances and improve safety in the office surgery setting.

Paul S. Nassif, MD of Beverly Hills, became a fellow of the American College of Surgeons during the 87th Annual Clinical Congress in New Orleans, November 2001.

John W. Pate, Jr., MD of El Paso, Texas, was named by the Texas Governor to sit on the Texas Board of Medical Examiners.

James N. Thompson, MD of Winston-Salem, N.C. has accepted the position of executive vice president of the Federation of State Medical Boards in Texas.

VIEW TEACHINGS NOW IN VIDEO-CD

Thirty-three of the most recent digital videotapes in the Academy’s Dickinson library have been converted to Video CD. (Please refer to the enclosed order form for a complete list.) This format provides low cost multi-platform compatibility and compatibility with many DVD players in the United States. Check your DVD Operations Manual to see if it is VCD compatible. This format enables those in other countries to view the latest programs on their PC or MAC computer in either Windows Media Player or Quicktime. Computer screen size is limited to 352 X 240 in full motion and visual quality is comparable to VHS. In a DVD player, these same discs provide full screen and full motion with surprising clarity. In addition to lower cost, the major reasons for venturing into Video CD format include small size, cross-platform compatibility, and no need for standards conversion in Non-NTSC countries.

To order copies of your own personal CD, complete the order form enclosed in this issue of Facial Plastic Times.

DEADLINE APPROACHING
You have until March 15, 2002 to submit abstracts for the AAFPRS Foundation’s Annual Fall Meeting in San Diego, CA. Please visit the AAFPRS Web site: www.aafprs.org/physician/submit_abstracts.html.

Enjoy a magical evening as you enter Central Park from 5th Avenue and are escorted to The Boathouse. New York City’s skyline sparkles over the treetops as you take your loved one on a candlelit gondola ride on the lake. Entertainment will abound and celebrities will be in attendance as you trip the light fantastic. PAINT THE TOWN has grown to be a tradition in New York City and chair Mrs. Tom Romo, III, does not want you to miss the boat on the Manhattan extravaganza. Sign up now to ensure your attendance. For more information, contact Ann K. Holton, director of development, research, and humanitarian programs at the AAFPRS Foundation office; (703) 299-9291, ext. 229 or by e-mail: aholton@aafprs.org.

Order your tickets now by completing this form or the registration form in the enclosed 8th International Symposium Brochure. AAFPRS Foundation, 310 S. Henry Street, Alexandria, VA 22314; Fax (703) 299-8898.

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Medem Update: Add AAFPRS Materials to Your Site, Create Your Own Categories

Organizing your patient education resources by categories of information is a great way to make your Web site more accessible and easy for patients to use. Initially, Medem provides five basic categories for your use: New Patient Information; Staying Healthy; Common Illnesses; Frequently Asked Questions; and Common Procedures. However, you can add your own categories by logging into www.medem.com (click Physician Login and enter your user ID and password). From the Practice View area of your Web site, click Patient Education, select the Organize Categories link, and then click on Add New Category.

Once you have added your new categories, you can organize your patient information resources by starting on the Patient Education page and selecting the appropriate link for the type of resource that you wish to categorize. Select Society Articles, Office Handouts, or Web Links and then highlight the category that you want to use from the drop-down menu that is listed in the Select a Category column on the right side of the page. Once you have made your selection, be sure to click the continue button to save your changes.

How to add articles to your practice Web site
Medem's On-line Medical Library is composed of peer-reviewed articles from leading medical societies, including the AAFPRS. You can add an unlimited number of articles to your Web site. When you initially build your site, your home page will display a few pre-selected articles based on your specialty.

Articles can be added either through a search or by browsing the Medical Library. Either way, start by logging in to your site as previously stated:

2a. Click Physician Login.
3a. Log in with your user ID and password. If you have forgotten your User ID and password, contact Medem member services at info@medem.com or toll free at (877) 926-3336. Once you have accessed Practice View, follow these steps to add an article using the search function:

1b. Click Patient Education, which is located under Web site: Your Name on the Practice View menu.
2b. Click Society Articles. Any articles that currently appear on your Web site will be listed on this page.
3b. Enter a search term. If you enter more than one word in the search field, the articles displayed will contain all the words entered. If you enter a word root followed by an asterisk (*), the search will return articles that match all available suffixes. For example, a search for cardio* will return articles containing cardiology, cardiomegaly, cardiomyopathy.
4b. Click Go.

5b. Click any article title to view the article. Articles are listed in descending order of relevance to your search term(s). Alternatively, you may click Add Now to add the article without reviewing it.
6b. Click Publish to add the article to your site. 7b. Select a category for the article from the drop-down list. The article will appear under this category title on your home page. Categories help patients find information more quickly. Create your own categories by clicking on Categories in the Patient Education menu.

To add articles using the browse function, follow steps 1a to 2b to get to Societies Articles. Then:
1c. Click Browse the Article List.
2c. Click any topic to display a drop-down list of subtopics.
3c. Click any subtopic to display related articles.
4c. Follow steps 5b to 7b.

How to remove articles from your practice Web site
To remove certain articles that appear on your site, select the article to be removed by placing a check next to the article title. Click Delete Checked Articles. Articles are not removed from our library, and you may add the article again at any time.

If you have any questions about building your Medem site and updating your existing Medem site, please call member services at (877) 926.3336.

Once your Web site is up and running, make sure you link it to the AAFPRS's Web site, which is accessible through the patient's Physician Finder Section.

AAFPRS Web Statistics
Did you know that www.aafprs.org receives over 1 million hits a month (a hit equals the number of times a page is visited regardless of who the visitor is) with an average of 40,000 visitors to the site each month?

In January 2002, the Academy’s Web site received:

- 2.3 million hits
- 66,000 sessions

The patient’s Physician Finder section is the most frequently visited page with over 16,000 viewers followed by the Patient’s Procedures page with 3,800 viewers. Within the physician’s Section of the site, the Physician Products area is most popular with 800 viewers followed by Education and Meetings with 680 viewers.

Link your site to the Academy’s Physician Finder section for only $350 for the first year and $100 each year after. See enclosed link application form for details.
Participation of Other Societies and IFFPSS:

From Cover Story, page 1

medical journals and received many research grants, including awards from the American Cancer Society, the Kellogg Foundation, and the American Academy of Otolaryngology. The AAFPRS presented her with the 1990 Journalism Award of Excellence for her five-part series on plastic surgery.

Friday morning begins with Saving Face: A Decade of Revolution in Facial Plastic and Reconstructive Surgery with Richard E. Hayden, MD. Currently a professor and chair of the Department of Otolaryngology–Head and Neck Surgery, MCP Hahnemann University, in Philadelphia, Dr. Hayden is an enthusiastic Academy member. He has participated in research, soft tissue, and microvascular and reconstructive surgery committees. Dr. Hayden is known for his work in tissue expansion and photodynamic therapy and was awarded the Investigator Development Award and the Bernstein Award.

Daniel C. Baker, MD, of New York City, will be addressing the symposium Saturday morning on Minimal Incision Rhytidectomy with Lateral Smasectomy. After serving in the United States Army Medical Corps, Dr. Baker completed a residency at NYU’s Institute of Reconstructive Plastic Surgery and today is an associate professor of surgery there. Dr. Baker was a key player in building the NYU Paralysis Clinic and the NYU–Bellevue Hospital Microsurgery Service.

Blepharoplasty–State of the Art, will be presented on Saturday by Glenn W. Jelks, MD, who is both board certified in plastic surgery and ophthalmology. A prestigious physician in both fields, Dr. Jelks is responsible for revolutionizing lower eyelid surgery and will bring a unique and qualified look at blepharoplasty. He is currently an associate professor of ophthalmology and surgery (plastic surgery) at the New York University School of Medicine.

Sydney R. Coleman, MD, known for his work in Lipo-Structure, has traveled the globe lecturing and demonstrating 2002–Latest Advances in Cutaneous Laser Surgery on Sunday. As a skillful dermatologist, he has been instrumental in developing new laser systems and therapeutic techniques used throughout the world. Dr. Geronemus is responsible for establishing the laser program at the New York University Medical Center and resides as chief of dermatologic and laser surgery. He is also the director of the skin/laser division in the Department of Plastic Surgery at the New York Eye & Ear Infirmary.

The Academy is excited to have the following societies involved in the educational program.

On Thursday, May 2nd, Martyn Mendelsohn, MD, will moderate a panel on Facial Plastic Surgery in Australia. The Australian Academy of Facial Plastic Surgery will be represented by panelists, Simon Braham, MD; George Marcells, MD; and Robert Hodge, MD.

On Friday, May 3rd, the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) will host a panel on Ethnic Blepharoplasty and Mid Facelift: Nuances of Anatomy and Surgical Management. Assemble with Jill A. Foster, MD; Paul Gavasis, MD; David E. Holck, MD; Michael Kazim, MD; and John D. Ng, MD, for an informative look at the popular ethnic procedures.

Also on Friday, Reconstructive Rhinoplasty will be addressed by the European Academy of Facial Plastic Surgery. Tony R. Bull, FRCS, will moderate with panel members, Pietro Palma, MD; Gerhard Rettinger, MD; Daniel Simmen, MD; and Gilbert J. Nolst Trenité, MD, respectively representing the United Kingdom, Italy, Germany, Switzerland, and The Netherlands.

On Saturday, members of the American Society of Dermatologic Surgeons, Alastair Carruthers, MD; Roy Geronemus, MD; Stephen
Mandy, MD; and Neal Sadick, MD, will discuss Non-ablative Rejuvenation.

The Canadian Academy of Facial Plastic and Reconstructive Surgery will be represented by Joseph K. Wong, MD; Peter A. Adamson, MD; John Dmytryshyn, MD; and David A.F. Ellis, MD.

To accommodate our Spanish-speaking colleagues, a translation service will be available during the general sessions.

The program has been constructed for the continuing education of medical students, residents, fellows, and practicing physicians in the field of facial plastic and reconstructive surgery. The curriculum is for physicians of all levels of experience and encompasses facial aesthetic and reconstructive surgery, trauma and congenital issues.

A detailed brochure is enclosed in this issue of Facial Plastic Times. Please peruse through the pages carefully as there are instruction courses and breakfast sessions that occur concurrently. When completing the registration form, make sure you specify the courses, workshops, or sessions you plan to attend each day; tickets will be issued and checked for attendance.

Don't forget about having a fun time in the city that never sleeps. Paint the Town on Thursday, May 2nd will be an evening you will cherish as you socialize with celebrities, local New Yorkers, and friends. Broadway plays are abundant and the nightlife is exciting. Tours are available for you and your guests. Make sure you sign up early.

SPECIAL THANKS TO THE PROGRAM COMMITTEE

The symposium would not be possible without the devotion and perseverance of a committed group of members. The Academy would like to extend a special thank you to the 8th International Symposium Planning Committee:

J. Regan Thomas, MD
Michael J. Sullivan, MD
Shan R. Baker, MD
Paul J. Carniol, MD
Ted A. Cook, MD
John F. Hoffmann, MD
Robert M. Kellman, MD
Keith A. LaFerriere, MD
Wayne F. Larrabee, Jr., MD
Ira D. Papel, MD
Norman J. Pastorek, MD
Stephen W. Perkins, MD
Vito C. Quatela, MD
Dean M. Toriumi, MD
S. Randolph Waldman, MD
Maryann P. Wall, MD
Boards Meet this Winter

The Board of Directors for both the Academy and Foundation met last January in Alexandria, Va. to discuss issues pertaining to the organization, its membership, and the field of facial plastic and reconstructive surgery. Listed below are some of the highlights of the meeting.

Academy Board
The following points outline the discussion and decisions made by the Academy Board of Directors.

► The Board recommended policy and bylaws changes to election procedures. These amendments will be reviewed by the Bylaws Task Force for final discussion at the next Board meeting in May.
► Staff was asked to provide the Board with an average of participating voters each year to determine membership involvement and to plan ways to maximize election participation.
► The special assessment for 2002 was discussed and the Board agreed to devote all funds toward legal and public relations efforts.
► Group vice president for public and regulatory affairs Ira D. Papel, MD, reviewed the legislative status in New York and Florida. The Academy’s public relations program was discussed in direct relation to the special assessment collection this spring. A task force was formed to review and follow the financial status of the program.
► Group vice president for membership Robert Kellman, MD, reported on the early and timely remittance of dues by Academy members.

AAFPRS Foundation
The Foundation Board of Directors discussed the following issues relating to the AAFPRS Foundation’s educational, research, and humanitarian programs.

► Secretary Peter A. Hilger, MD, reported on COSM activities and a task force was appointed to review our involvement with future meetings in conjunction with COSM.
► The next FACE TO FACE trip to Russia is planned for October, 2002.
► Staff was instructed to contact the Rhinologic Society to clarify whether or not joint meetings will continue in the future.
► The AAO-HNS has instituted a management fee payable by the AAFPRS Foundation for joint meeting planning.
► Scott A. Tatum, MD, was commended for his diligent work in producing the new patient brochure Cleft Lip and Palate.
► It was agreed that the Fellowship Program requirements and accompanying manual will be amended to accommodate the Royal College of Surgeons.
► Staff was directed to send all new program directors a copy of the CME Directors Handbook and to include them on the CME Committee as ex-officio members beginning this fall.

A strategic planning session coordinated by president Shan R. Baker, MD, was held in between meetings, which included staff participation. The group broke into five sessions each one discussed a specific issue. They included: membership; public relations and marketing; CME and fellowship; development and fund raising; and office administration and ABFFPRS. Each group had a number of questions to answer and report back to the full Board at the end of the day. For instance, the development and fund raising meeting headed by Dr. Kridel presented three goals. They include: increase the number of individuals who donate to Annual Giving; increase new Paint the Town venues; and increase corporate participation. In addition, the Strategic Development Committee has already been tasked with securing funding for our building.

Abstract
In preparation for the 8th International Symposium of Facial Plastic Surgery, this column will publish abstracts to be presented at the symposium. This month, we feature two abstracts: one on cranial reconstruction and one on lipofilling.

Cranial Reconstruction with Composite Implants of Hydroxapatite Cement (HAC) and Osteogenic Protein-1: Outcomes with Post-reconstruction Radiation by R. Horioglu, MD; C. Friedman, MD; L. Chow, MD; S. Takagi, MD; D. Rueger, MD; and P. Costantino, MD.

Objective: To evaluate the clinical and histologic outcomes of cranial bone reconstruction with post-reconstruction irradiation, utilizing composite implants of hydroxapatite cement (HAC), recombinant human osteogenic protein-1 (OP-1), and modified bovine collagen matrix.

Methods: Critically sized full-thickness parietal skull defects (2.5 cm diameter) were created bilaterally in 6 female cats. One side was reconstructed using composite mixture of HAC/OP-1 device. The opposite side was repaired with HAC alone. The cranium was irradiated with a single dose of 1500 rads of external beam radiation four weeks postoperatively. Gross examination, diametral strength testing, CT imaging, histologic, and histomorphometric techniques were used to analyze the reconstructed areas at 90 days post surgery, with respect to appearance, structural integrity and strength, implant resorption, and osseous regeneration.

Results: One experimental animal died from post-operative pulmonary complications on day one. There were no implant related infections or extrusions. Gross inspection of implants on both sides revealed intact shape, contour, and volume. Both implant groups demonstrated osseointegration and active bone regeneration at the implant/bone
interface. Diametral tensile strength of the interfacial areas on both sides were equal to or greater than that of control cat cranial bone. Histologic and histomorphometric analysis revealed that 65.7 percent of the HAC/OP-1 composite implant was replaced by new bone, in contrast to 11.2 percent on the pure HAC side.

Conclusions: Composite implants of HAC/OP-1 are able to function as a cranial bone substitute and tolerate without significant sequelae post-operative radiation. Presence of OP-1 significantly accelerates the process of implant replacement with new bone formation. Post reconstruction radiation impairs the process of implant conversion to new bone.

Ultrastructural Evaluation of Stored and Injected Fat in Multiple Stage Lipofilling: The Electronic Microscope Surface Scan of the Injected Fat by D. Bertossi, MD; A. D'Agostino, MD; A. Bedogni, MD; A. Fior, MD; M. Albanese, MD; L. Trevisiol, MD; and P. Nocini, MD.

Background and Purpose: In the last 10 years, free fat autografts were discontinued because of the poor long-term results. Currently many reports on face lipofilling have a minimum follow-up of two years up to six years. Nowadays, there are two theories supported by histological studies (the host replacement theory or the cell survival theory) that underline fat tissue survival. We present a multiple stage technique of lipofilling on 99 cases of facial grafting by means of lipolayering. In 10 of these patients we associated histological and ultrastructural check-ups. The histology demonstrates that, if harvested with the right technique, fat tissue has the ideal dimensions to be grafted, resulting in good soft-tissue substitution.

Material and Method: We treated 99 patients with a three-step treatment with injections every 20 days of fat stored at -30 degrees Celsius. We also evaluated the histological and ultrastructural results in 10 selected patients treated with fat grafting on the upper lip after two and eight months in several biopsies on a specific site.

Results: With this technique there have been no complications. There was one case of hypotension and two cases of haematoma. There were no infections and there was a very low incidence of complications. The histological study of stored fat at 20 days and eight months of 10 patients and also biopsies of injected fat at two and eight months demonstrated that stored adipocytes seem to maintain their anatomical features and, that multiple stage injections were adequate to obtain good clinical results.

Conclusions: Lipofilling of the face seems to be an adequate graft material if one has the experience to do the right technique of harvesting, grafting, and storage of fat tissue. We had good results in our patient group with absence of complications and good results after three years.
DIGITAL CORNER: IMAGING SOFTWARE

By Sam Lam, MD

The first four articles in this series addressed the two principal input devices, digital cameras and scanners, used to obtain digital images. Now that the image has been captured, let's discuss how to compress, edit, archive, and morph that image.

Compression
Hundreds of compression algorithms have been developed over the years to reduce an image's size with minimal adverse effect on image quality. A list of the more popular formats would include TIFF, JPEG, GIF, PICT, PES, BMP, Flashpix, and PhotoCD. For all practical purposes, the facial plastic surgeon should only really be concerned with the first two mentioned, TIFF and JPEG. TIFF, or Tagged Image File Format, represents a form of lossless compression in which, as the name implies, there is no loss of image resolution after the image is compressed. The main drawback of this type of compression is the relatively small compression ratio that is achievable, usually only 2:1 or 3:1, leaving massive files of several megabytes. JPEG, or Joint Photographic Experts Group, represents a lossy compression algorithm in which there is loss of quality, usually unappreciable to the human eye, but that allows significant compression of a file in the order of 10:1 up to 300:1. Obviously, the more a file is compressed the greater the loss of resolution, albeit usually minor. Due to the degree of compression attainable with JPEG, it is more widely used than TIFF when handling digital images, except in the professional photographic market which demands perfection in their printed material.

As it is a lossy compression, the downside to JPEG is the loss of quality every time that a JPEG file is saved. If it is simply opened and closed without alterations, there will be no loss of quality. If one intends to work extensively with a JPEG image, it is advisable to leave a copy of an original JPEG image, or for better quality, a TIFF image, unaltered and stored in your files. JPEG 2000, a new JPEG algorithm, to be released sometime this year, will allow radical compression of a file with minimal loss of resolution. Practically, the facial plastic surgeon will not notice any appreciable loss of information with JPEG and will doubtfully modify a JPEG image repeatedly until it is significantly degraded.

Editing Software
The often-cited reason to avoid digital photography in facial plastic surgery is the capability of altering images unethically or even illegally. This is a misguided statement as 35-mm prints and slides can be easily altered as well. For example, a slide can be scanned, then altered on morphing software, and reprinted into a slide format. Furthermore, high-quality archiving software designed for plastic surgery, such as the Canfield product, has a built-in authentication protocol to detect altered, or doctoried, images. Editing software is often not critical for the facial plastic surgeon as digital images of patients usually require little editing (ethically, of course) before entry into an archiving database. Moreover, editing software is often included in archiving and morphing software or with the purchase of a scanner.

What constitutes ethical editing of a digital image? A digital image can be color balanced effectively and the hues and brightness adjustments made just as if you had sent your film to a professional lab processing plant. Eliminating dust and scratches and restoring color to a slide should be considered legitimate editing. Eliminating extraneous elements so long as it does not alter the image integrity through cropping should be acceptable. Rotating an image to achieve the Frankfort Horizontal Plane may be deemed unethical by some; but, in my opinion, if the pre- or post-operative result is not affected, I don't believe this should constitute an ethical violation. One can also label an image for an academic presentation using editing software. If used appropriately, editing software can be a powerful tool to ensure consistent, high-quality, artifact-free, photographic images.

Archiving Software
Many archiving software programs exist, some designed for plastic surgery specifically and others with a more general intended purpose--both of which can serve the need of a facial plastic practice. The two main types of archiving software are browser and catalog. The former type refers to the basic archiving programs, usually bundled free with digital cameras, that allow only simple retrieval of graphic images. Catalog programs, on the other hand, are more sophisticated and can handle many file types and attach metadata to each file. Metadata refers to all the descriptive fields that can be attached to a file to help locate it, e.g., Susan Smith, Crooked Nose, and Revision Rhinoplasty. It is often easier to retain the unintelligible name of an image file that the digital camera assigns, such as DSC_1789.jpg, and simply add descriptive metadata to it. Catalog software often will present thumbnails, or thumb-sized images of the image files, to identify them more quickly and easily.

Catalog-type archiving software can cost as little as $100 to several thousands depending on the features and integration with morphing software. Often the inexpensive software will perform quite well and provide all the features that one needs. Some of the more popular archiving software programs that are sold independently of image morphing software and are also intended for general archiving needs...
Decisions, decisions, decisions... to practice only facial plastic surgery or to take arms against a sea of trouble and practice both facial plastic surgery and otolaryngology. Paul E. Kelly, MD of Dover, Del., and Paul S. Nassif, MD of Beverly Hills, share their thoughts on the subject.

**Combined Practice** by Paul E. Kelly, MD

Deciding on a post-fellowship or post-residency practice pathway is complicated in the least, and multifaceted for certain. My decision to join an established otolaryngology practice takes root in my desire to start a facial plastic practice from the ground up yet have the ability to support my young family with my base in ENT. Joining an established group with a specific vision for facial plastic development was key—not only from a support perspective but from a market readiness perspective as well. Many otolaryngology groups seek young associates but few specifically seek one fellowship trained in facial cosmetic and reconstructive surgery.

In the ideal and unencumbered world, a practice pathway may be chosen based simply in love of one’s specialty or specific talent. Often, however, undeniable factors must be considered such as personal debt, dependents, and financial flexibility. A successful facial plastic surgery practice within an otolaryngology setting can be achieved through hard work, by specifically marketing oneself as a facial plastic surgeon (who also does some ENT), and by creating a vision to be realized in due course. My pathway has been extremely rewarding and challenging. Taking pride in my roots and emphasizing my fellowship training has allowed me the ability to do otolaryngology with all its benefits while also building a reputation and an all inclusive facial plastic surgery practice.

**Exclusive Facial Plastic Surgery** by Paul Nassif, MD

During my fellowship, J. Regan Thomas, MD, always emphasized the importance of focusing on establishing a practice exclusively based in facial plastic and reconstructive surgery from day one. The premise of his statement is that mixing otolaryngology with facial plastic surgery during the start of your practice may dilute the cosmetic practice and eventually, hurt the growth of the cosmetic practice. Sure, in the short run ENT can be a great profit generator. But, in the long run, it may stunt your facial plastic surgery practice. The reasons this may occur include the lack of the general publics’ understanding of an otolaryngologists’ training and qualifications and that practicing general ENT may also fuel competitive practitioners in other fields to doubt your qualifications. The mix of children, head and neck patients, and cosmetic patients in the waiting room of the office also may be difficult for some personalities. Finally, a busy general ENT practice tends to drain your energy from what is necessary to develop the cosmetic practice.

**Conclusion**

Few would argue that numerous routes are available to achieve success within a specific specialty. The above expressed viewpoints, while opposing in general set-up and philosophy, do find common ground in the desire to build the facial practice from the ground up and the vision of success within this field. Challenges and problems will be encountered in each of these scenarios—from financial concerns to public perception. Upcoming articles will address these issues in attempts at helping those in process navigate their chosen course.

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The AAFPRS administrative office has a few copies of the monograph series titles published by Thieme Medical Publishers. They are for sale on a first-come-first-serve basis.

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- *Reanimation of the Paralyzed Face* (L. Burgess and R. Goode, 1994) 2 copies only $35/each
- *Free Flap Reconstruction of the Head and Neck* (W. Panje and W. Moran, 1989) 1 copy only $35
- *Principles of Photography* (M.E. Tardy, 1992) 2 copies only $35/each
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- *Dermabrasion and Chemical Peel* (E.G. McCollough and P. Langsdon, 1988) 1 copy only $35
- *Biological Basis of Facial Plastic Surgery* (A. Meyers, 1993) 2 copies only $35/each

To order, please contact Kim Middleton at the Academy office, (703) 299-9291, ext. 234 with a credit card payment.
From Digital Corner, page 12 include Canto Cumulus 5.0 (www.canto.com), Extensis Portfolio 5.0 (www.extensis.com/portfolio), and ImageAxs Pro (www.caere.com/products/imageaxs). The subtle differences between these programs are beyond the scope of discussion, and the reader is referred to the above Web sites for further information on these products. Archiving software can also be sold bundled (or separately) from image morphing software such as the Mirror DPS or Photofile (www.canfieldsci.com) or a similar product, My Archiving, by United Imaging (www.uimaging.com).

One may also like to consider the potential for integrating archiving software with a patient medical-record database, such as Nextech (www.nextch.com).

**Morphing Software**

Morphing software allows the surgeon to simulate post-operative results through the use of advanced morphing algorithms. Similar to archiving programs, morphing software programs may also be bundled with archiving programs or sold independently. As mentioned above, the two most popular morphing programs are the Canfield Mirror Suite and the United Imaging System, both of which come with image management software. AlterImage (www.seattlesoftwaredesign.com) manufactures an image morphing software without archiving capabilities and is intended to be linked with one of the aforementioned archiving programs. The controversy of image morphing has not been settled, and camps are equally divided between the benefits of patient education and communication that the software provides vs. the inflated expectations that may have dire medicolegal consequences if post-operative results fall short of expectations.

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Hands on Course: Endonasal Sinus and Skull Base Surgery. August 21-23, 2002 in Zurich, Switzerland. Contact: PD Dr. Daniel Simmen, Dr. Hans Rudolf Briner, ORL-Zentrum, Klinik Hirslanden, Witellikerstrasse 40, CH-8029 Zürich, Switzerland; fax: (+41) 1 387 28 02; e-mail: info@orl-zentrum.com; Web site: www.orl-zentrum.com.

9th International Course in Modern Rhinoplasty Techniques & Symposium ‘The Ethnic Nose’ Academic Medical Center, Amsterdam, The Netherlands, October 10-12 2002. Contact: Gilbert Nolst Trenite, MD, PhD, P.O. Box 227000/A2-233, 1100 DE Amsterdam, The Netherlands; e-mail: M.B.vanhuiden@amc.uva.nl.

2nd Biennial International Instructional Masterclass; Consensus and Controversies in Sinonasal and Skull Base Endoscopic Microsurgery and Advanced Rhinoplasty and Facial Plastic Surgery. March 20-26, 2003 in Milano, Italy. Contact: Paolo Castelnuovo, MD and Pietro Palma, MD at: e-mail: ppalma@digibank.it; fax: (+39) 02 6361-8770; Web site: www.milanomasterclass.it.

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