FACIAL PLASTIC SURGERY 2.0

On-Site Program and Proceedings

AAFPRS
Fall Meeting

New speakers, new topics, new format...New Orleans!

Co-chairs
William W. Shockley, MD
Steven H. Dayan, MD

THE NEXT GENERATION
October 19-21, 2013
New Orleans, LA
We’ve Mastered the Art of Facial Implants

Leader in silicone, ePTFE and custom facial implants.

Visit us at the AAFPRS Fall Meeting, Booth 511
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All meetings and sessions of the AAFPRS Fall Meeting will be held at the Sheraton New Orleans Hotel -- in the heart of the Big Easy. It’s address is: 500 Canal Street, New Orleans, LA 70130; phone: (504) 525-2500. Work, play or simply relax at our New Orleans hotel, centrally located within an atmosphere of endless excitement from the heart of one of the world’s greatest cities. Arise to a breakfast of beignets and café au lait just steps from the French Quarter. Spend an afternoon shopping Royal Street and the French Market. Relax in Jackson Square or dine at a world famous restaurant in the French Quarter. Hear the sultry tones of a late night jazz show.
We are excited to welcome you to New Orleans! The city is famous for Mardi Gras, the French Quarter, Bourbon Street and the Super Dome. New Orleans is renowned for its fantastic cuisine, music, jazz brunches, and streetcar tours. The “Big Easy” is full of fun, festivities, art and culture. Families can visit the Audubon Zoo, Aquarium, and Mardi Gras World or you can dance the night away in the French Quarter. New Orleans has something for everyone and we are excited that this year’s fall meeting will take place in this rejuvenated historical city. This will serve as a perfect backdrop for one of our most innovative educational ventures.

The theme for this year’s meeting is **Facial Plastic Surgery 2.0.** As the name implies we have made dramatic changes from our traditional meeting format. This year’s meeting offers four educational tracks; aesthetics, non-surgical, practice management and reconstructive. The new format allows us to offer an unprecedented number of speakers, topics, ideas and learning opportunities. As you review the program, you will be amazed how much we have been able to pack into this three day meeting including dozens of speakers, multiple panels, and nearly 80 instruction courses. The expanded simultaneous sessions have allowed us to provide an expansive coverage of topics in facial plastic surgery and practice management.

In our non-surgical track, some of the topics covered include: concepts of beauty, popular cosmetic procedures, advances in neurotoxins and fillers, as well as avoiding and managing pitfalls and complications. We have speakers from multiple specialties including facial plastic surgery, plastic surgery, oculoplastic surgery, and cosmetic dermatology.

The aesthetic track concentrates on new and innovative techniques that are related to facial rejuvenation procedures. This includes a host of surgeons discussing their techniques with respect to facelift, brow lift and blepharoplasty. There are sessions devoted solely to fat transfer, hair transplantation, and otoplasty.

The practice management track is likely to be one of our most popular features this year. We will hear from many experts in marketing/social media, office management and multiple other topics related to building and maintaining a successful practice.

In the reconstructive and aesthetic track, one entire day is devoted to rhinoplasty. We are excited to have as our guests Dr. Rod Rohrich and Dr. Bahman Guyuron, as they offer their perspectives in rhinoplasty. In the reconstructive track, one session is devoted to nasal reconstruction and highlights our featured speakers, Dr. Gary Burget and Dr. Shan Baker.

The final day of the session is devoted to challenging cases in reconstruction and rhinoplasty. This includes defects related to neoplasms, trauma and Mohs defects. We are also happy to have Dr. Tri Nguyen (Mohs Surgeon) as our featured speaker who will discuss an update on Mohs surgery as well as his perspectives on reconstruction of facial defects.

We would also like to recognize the tremendous program that has been put together by the Organization of Facial Plastic Surgery Assistants (OFPSA). Year in and year out this organization always has outstanding programs. We want to remind you that you are completely welcome to attend any of the sessions offered. Many of these apply directly to your practice and your professional success.

This year, we are also hosting numerous social events and scores of exhibitors who will feature the latest in facial plastic products and services. We are also happy to remind you that there will be several sessions around the time of the meeting that will also be of interest to you and will be sponsored by some of our most loyal exhibitors.

**Facial Plastic Surgery 2.0** is a multidisciplinary event. We not only have many speakers and participants from multiple specialties but also a significant number of attendees who represent other specialties who have an interest in facial plastic surgery. We are proud of the educational opportunities that we have put together. We think that this is a meeting that people will remember and will be talking about for some time.

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**WELCOME FROM THE AAFPRS PRESIDENT**

Welcome to the 48th Annual Fall Meeting of the AAFPRS. This is going to be a very special meeting, and I look forward to seeing everyone here. Of course, we are back in New Orleans for the first time since the great hurricane that nearly destroyed the city. Besides the many cultural and entertainment activities available, our commitment to supporting the economy of this great city should be an attraction to all of our members. This is also the first time that our meeting is taking place independently, without the AAO-HNS. As a stand-alone meeting, I appreciate your being here to show your support for your Academy and to take advantage of the many educational offerings available. There is something for everyone here. Our marvelous program chairs, Drs. Shockley and Dayan have worked tirelessly to orchestrate a complex program with four tracks, allowing for many more offerings than the typical Fall Meeting. In addition, our named lecturers offer some new and fascinating material, including, our Jack Anderson lecturer, Michael Super, PhD, a scientist from the Wyss Institute in Boston, who will be talking about the creation of new and better implants that can even resist bacterial colonization and our John Conley lecturer, David Buss, PhD, a psychologist who has studied the evolution of human attraction. Of course, our very own Peter Adamson, MD, our Gene Tardy Scholar will address the membership with his lecture on “Facial Plastic Surgery: Your Future is Our Future.”

Thanks for being here and let’s make this meeting memorable and wonderful.
Target Audience
The meeting is offered for continuing medical education of medical students, residents, fellows, and practicing physicians (MDs and DOs) in the field of facial plastic and reconstructive surgery. The program is for physicians with all levels of experience and covers aesthetic, reconstructive, and congenital issues relevant to this specialty.

Accreditation/Credit Designation
The AAFPRS Foundation is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The AAFPRS Foundation designates this live activity for a maximum of 28.25 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Learning Objectives
The course directors, AAFPRS Foundation, and CME Committee strive to formulate a program that is contemporary, unbiased, and relevant. After attending the plenary sessions, the participant should be able to:
- Recognize the multiple modifications of facelift surgery and apply them appropriately.
- Detail the current approaches, which can be used for periorbital rejuvenation.
- Discuss the concept of a comprehensive approach to midface rejuvenation.
- Identify ideal candidates for fat transfer and explain the techniques involved leading to a successful outcome.
- Detail the tenets related to successfully managing your office staff.
- Describe the principles involved in choosing new technology and applying it to your practice.
- Discern the differences between attractiveness and beauty.
- Discuss the principles and techniques for the current use of neurotoxins and fillers.
- Perform the micro-cannula technique for injection of facial fillers.
- Recognize the nuances of fillers and neurotoxins for periorbital and perioral rejuvenation.
- Detail the possible pitfalls and complications associated with neurotoxins and fillers.
- Discuss appropriate patient selection with respect to the use of the appropriate lasers, understanding which laser works best for a given skin condition.
- Explain the various treatment algorithms for tip contouring and projection in rhinoplasty surgery.
- Detail the secrets to success in correcting the crooked nose.
- Compare and contrast methods of nasal reconstruction for small to medium nasal defects.
- Recognize the techniques that are most successful in performing revision surgery following nasal reconstruction.
- Compare and contrast the Nagata technique and the use of alloplastic implants in microtia repair.
- Discuss the surgical techniques available in reconstruction of facial defects involving the face, lip, and ear.
- Recognize how to apply contemporary concepts in nasal valve surgery.

Exhibition
(Napoleon Ballroom) The exhibition will be at the Sheraton New Orleans Hotel and will have nearly 100 companies featuring their latest products and technology. All breaks and lunches, as well as the Pre-registration Party and Welcome Reception, will be held in the Exhibit Hall to maximize your time with our loyal exhibitors. The Exhibit Hall will open on Saturday, October 19, 2013 and will close after the lunch break on Monday, October 21, 2013. Only registered attendees will be admitted into the exhibit area.

Exhibit Hall Presentations
Meeting co-chairs, William W. Shockley, MD and Steven H. Dayan, MD, are pleased to announce industry presentations (non-CME) in the Napoleon Exhibit Hall, Center Stage, during breaks and lunches. Find out what the buzz is all about from industry leaders and doctors that have implemented their findings in their practices. We are fortunate to have the participation of Ceatus Media Group LLC; Restoration Robotics, Inc.; and Ellman International, Inc.

Fellowship Directors Luncheon
(Waterbury Room) All AAFPRS fellowship directors are invited to a luncheon on Saturday, October 19, 2013 from 12pm to 1:00pm.

Founders Club Dinner
A dinner for all Founders Club members will be held off-site on Sunday, October 20, 2013 from 8:00pm to 11:00pm, and is by invitation only.

Live Auction

Past Presidents’ Dinner
A dinner for all AAFPRS past presidents will be held off-site on Saturday, October 19, 2013 from 7:30pm to 11:00pm, and is by invitation only.

Registration
(Napoleon Ballroom Foyer) Pre-registered attendees may pick up their packets on Friday, October 18, 2014 between 5:00pm and 7:00pm in the Exhibit Hall during the Pre-registration Party. On Saturday, Sunday, and Monday, registration will be located in the Napoleon Ballroom Foyer. Pre-registered attendees may pick up their packets on Friday, October 18, 2014 between 5:00pm and 7:00pm in the Exhibit Hall during the Pre-registration Party. On Saturday, Sunday, and Monday, registration will be located in the Napoleon Ballroom Foyer.

Spouses Luncheon
The Spouses Committee invites you to their annual luncheon on Monday, October 21, 2013 from 12:00pm to 2:00 pm at a local venue. Please visit the registration desk to sign up.

Welcome Reception
All registered attendees are invited to the Welcome Reception on Saturday, October 19, 2013 from 6:30pm to 8:00pm in the Exhibit Hall. Guests and spouses who are not registered for the meeting may purchase a ticket to attend the reception.

1887 Reception
(Armstrong Ballroom) Do you have an 1887 Ribbon? If so, come by the 1887 Reception on Sunday, October 20, 2013 from 7:00pm to 8:00pm.
The popular AAFPRS Video Learning Center will be in the Exhibit Hall (booth 100-110) and will be open to all meeting attendees. The John Dickinson Memorial Library has over 275 procedural and instructional DVDs which you can preview at the meeting. You may also purchase the DVDs on-site and receive a 10% meeting discount. Come check out the recently released rhinoplasty DVDs which will be shown during the breaks.
Pre-Registration Party
Friday, October 18, 5:00pm-7:00pm
(Napoleon Ballroom) Attention pre-registered attendees. Avoid long registration lines on Saturday morning and enjoy a relaxing early evening drink while you pick up your registration packet for the meeting in the Exhibit Hall on Friday, October 18th, from 5:00pm-7:00pm.

The AAFPRS Foundation wishes to thank Myoscience for their non-educational grant. Myoscience, the proud sponsor of the first Pre-Registration Party, wants you to chill out at the unique ice bar that will be provided.

Enjoy catching up with old friends and thanking the exhibitors for supporting educational excellence which is showcased at every AAFPRS scientific meeting.

Friday Night CME Program
(Grand Chenier Room)
Rhinoplasty, Implants, Scaffolding and Adjunctive Materials
Friday, October 18, 7:00pm-9:00pm

Tip and Pearls to Technically Ease the Placement and Positioning of Grafts
Dean M. Toriumi, MD
Total Septal Reconstruction
Gilbert Nolste Trenité, MD
Nasal Scaffolding: Creating a Support Structure
Tom Romo, MD
Advancements in Rhinoplasty: Implants and Adjuncts
Tom D. Wang, MD

INVITED GUEST SPEAKERS

Jack Anderson Lectureship
This year’s Jack Anderson Lectureship will be given by Michael Super, PhD. Dr. Super is part of the The Wyss Institute’s Advanced Technology Team, which consists of scientists and engineers with expertise and training in biomaterial fabrication and device development. These technical experts help to guide the material and device development efforts of the Enabling Technology Platforms, mentor staff and students in the technology translation and intellectual property areas, and provide institutional memory.

John Conley Lectureship
The Academy is excited to welcome David M. Buss, PhD, professor of psychology at the University of Texas, Austin, as the John Conley lecturer. Dr. Buss began his academic career as an assistant professor at Harvard University for four years then migrated to the University of Michigan for 11 years. In 1996, he accepted his current position at the University of Texas, and is known for his evolutionary research on human sex differences in mate selection. You will not want to miss his presentation, “The Evolution of Sexual Attraction”—which will be as interesting as the title suggests.

Gene Tardy Scholar Lectureship
We are honored to have as this year’s Gene Tardy lecturer--Peter A. Adamson, MD. Dr. Adamson is a past president of the AAFPRS and remains to be an active member with committee assignments and involvement in special projects.

Since launching his highly successful Toronto practice in 1981, Dr. Adamson’s excellence in facial plastic surgery has consistently inspired the loyalty and trust of patients from all walks of life. From pre-operative assessments to formulation of treatment plans and post-operative care, his informed, supportive and collaborative approach has benefited thousands of patients, empowering each one to face the future with renewed confidence.

Dr. Adamson’s lecture, “Facial Plastic Surgery: Your Future is Our Future,” will be on Monday, October 21.

The AAFPRS Foundation thanks Canfield Imaging for their involvement in the Exhibit Hall contest--Canfield VECTRA® 3D Face Off--with a non-educational grant (see page 17).
DAY 1 - SATURDAY, OCTOBER 19, 2013

TRACK 1 - NON-SURGICAL (Grand Ballroom D)

Why Do We Do What We Do?
Moderator: Peter A. Adamson, MD

8:00am Male Attractiveness following Feminization Facial Plastic Surgery Procedures
Jeffrey Spiegel, MD
8:15am Beauty Through a South American Lens
Roxana Cobo, MD
8:30am Do Beautiful People have a Beautiful Life?
Nabil E. Fanous, MD
8:45am Beauty and Health: Designing AfroModern Well-Being
Monte O. Harris, MD
9:00am More than Just Attractive: The Face as it Relates to Personality
Michael Reilly, MD
9:15am Natural Beauty
Peter A. Adamson, MD
9:30am Facial Beautification: Think Beyond Rejuvenation
Hyoung Jin Moon, MD
9:45am The Rewards of Facial Expression
Daniel S. Alam, MD
10:00am Break and Presentations in the Exhibit Hall

Meet The Demand! Most Popular Cosmetic Procedures in America
Moderator: Benjamin Bassichis, MD

10:30am Let Anatomy Drive Your Focus
Rebecca Fitzgerald, MD
10:50am Global Approach to Rejuvenation
Doris Day, MD
11:10am How Do I Do It?
Heidi Waldorf, MD
11:30am Fillers in the Nose
Hyoung Jin Moon, MD
11:50am Experience with a New Midface Volumizing Hyaluronic Acid Filler
Derek Jones, MD
12:00pm Lunch and Presentations in the Exhibit Hall

Rethinking Neurotoxins and Fillers
Moderator: Mark Hamilton, MD

1:00pm Panel: My Perspective May Be Different than Yours
Moderator: Corey S. Maas, MD
Panelists: Babak Azizzadeh, MD; Rebecca Fitzgerald, MD; Theda C. Kontis, MD; Jason Pozner, MD; Heidi Waldorf, MD; and Julie Woodward, MD

1:50pm Autologous Fillers, Pros and Cons
John Joseph, MD
2:00pm Neurotoxins and Blepharospasms
Julie Woodward, MD
2:10pm How to Minimize Bruising with Facial Fillers
Daniel C. Daube, MD
2:20pm Minimally Invasive Facial Remodeling
Lisa D. Grunebaum, MD
2:30pm Multi-Filler Layered Combination Injections with Blunt Tip Cannula
Jason Meier, MD
2:40pm Use of Micro Cannula for Filler Injections
Paul Leong, MD
2:50pm Micro Cannula Technique for Injection of Facial Fillers
Kian Karimi, MD
3:00pm Break and Presentations in the Exhibit Hall

Rethinking Neurotoxins and Fillers
Moderator: Jason Bloom, MD

3:30pm Update on Bovine Collagen/PMMA: An FDA Approved Permanent Facial Filler
Samuel M. Lam, MD
3:40pm Lip Fillers: Clinical and Ultrastructural Analysis
Dario Bertossi, MD
3:50pm Filler Under Eyes with Cannulas
Paul Yazbeck, MD
4:00pm Filling the Tear Trough
Brian Downs, MD
4:10pm The PLLA Algorithm
Jason Bloom, MD
4:20pm Perioral Fillers to Achieve Natural Results
Jefferson Kilpatrick, MD
4:30pm Comparison of Neurotoxins in the U.S.
Amir Moradi, MD
4:40pm New Indications for Neurotoxins
Derek Jones, MD
4:50pm Coveted Nuances with Fillers and Neurotoxins
Benjamin Bassichis, MD
5:00pm Practical Approaches to Fillers and Neurotoxins
Timothy Greco, MD
5:10pm Anatomic Guidelines in Facial Fillers
Ryan Greene, MD
5:20pm Liquid Injectable Silicone: Over 1,500 Procedures
Eric Joseph, MD
5:30pm Periorbital Region: Advanced Thinking
Robert A. Goldberg, MD

Avoiding Complications and Managing Pitfalls
Moderator: John Joseph, MD

5:50pm Blindness Due to HA's
John Joseph, MD
6:00pm Nasal Injection Complications
Hyoung Jin Moon, MD
6:10pm Despite What Patients Want, Don't Do It
Timothy Greco, MD
6:20pm Crash Cart Essentials
Steven H. Dayan, MD
DAY 1 - SATURDAY, OCTOBER 19, 2013

TRACK 2 - PRACTICE MANAGEMENT  (Grand Ballroom B) (Non-CME)

The Big Easy: Simple Answers to Doctors Biggest Questions

How Do I Create A Luxury Brand?
Moderator: Candace Crowe

8:00am  Development of a Brand
         Erica Bazerkanian
8:15am  Specialty Branding for a Signature Treatment
         Hyoung Jin Moon, MD
8:30am  The Lagniappe Secret to Branding
         Tracy Drumm
8:45am  Just What is your Identity, Brand, and Tagline?
         Just Do It!
         Candace Crowe
9:00am  Can I Provide the Ritz Carlton Experience to
         My Patients?
         Denise Keeler
9:15am  Panel: New Horizons: How Do I Successfully Change
         My Practice Structure?
         Daniel Becker, MD; Michael Paciorek, MD; David W. Kim, MD; Keith A. LaFerriere, MD; Steven J. Pearlman, MD; and Adam Schaffner, MD

10:00am  Break and Presentations in the Exhibit Hall

Am I Getting the Most Out of My Staff?
Moderator: Jay Shorr

10:30am  Non-Competition Clauses to Protect Your Practice
         and Gain Loyal Employees
         Alex Thierson
10:45am  Hiring, Firing and Motivating
         Jay Shorr
11:00am  The Anatomy of an Invaluable Worker
         Karen Zupko
11:30am  Hiring, Training, Motivating a Top Patient Advisor
         Jon Hoffenberg
11:45am  What You and Your Staff Need to Know about
         E-mailing and Texting with Your Patients
         Mike Sacopulos, JD

12:00pm  Lunch and Presentations in the Exhibit Hall

How Do I Maximize the Benefits of Attending Conferences?
Moderator: S. Randolph Waldman, MD

1:00pm  How to Make an Impactful Presentation
         Jonathan M. Sykes, MD
1:15pm  How Conferences Can Grow a Practice
         Jeff Kilpatrick, MD
1:30pm  Using Conferences to Promote Your Practice via
         Social Media
         Samuel M. Lam, MD
1:45pm  Creating Opportunities at Conferences
         S. Randolph Waldman, MD

How Do I Manage a Practice While Keeping Patients My First Priority?
Moderator: Dana Fox

2:00pm  Virtual Consultation Dos and Don’ts
         Catherine Maley
2:15pm  To Pay or I’ll Call You Later: How to Collect Deposits
         and Book During a Consult
         Jon Hoffenberg
2:30pm  Overhead and Operations: Cutting Where it Counts
         Jay Shorr
2:45pm  Why Do Smart, Talented Doctors Leave So Much
         Money on the Table?
         Dana Fox

3:00pm  Break and Presentations in the Exhibit Hall

3:30pm  What are the Warning Signs of Embezzlement
         and Fraud?
         Mike Sacopulos
4:00pm  Presentation Panel: I Have A Game-Changing Idea,
         What are My Next Steps?
         Samuel M. Lam, MD; Denise Mann and Tom Seery
4:45pm  Panel: The Entrepreneurs: From Patients to
         Pipelines, Promotions and Programming
         Moderator: Jeffrey S. Epstein, MD
         Panelists: Mark Glasgold, MD; Harry Mittelman, MD; Corey S. Maas, MD; Jason Pozner, MD; Edwin F. Williams, III, MD; and S. Randolph Waldman, MD

Can I Get Even More Return with Technology?
Moderator: Donn R. Chatham, MD

5:30pm  How to Incorporate EMR and Obtain Government
         Incentive Payments in a Facial Plastic Surgery
         Practice
         Jason Meier, MD
5:45pm  Technology as a Driving Force for Your Practice
         Jason Pozner, MD
6:00pm  Gizmos, Gimmicks Or Great? Choosing Technology
         Wisely
         Donn R. Chatham, MD

AAFPRS Program Updates

6:15pm  LEARN – The AAFPRS Educational Portal
         Theda C. Kontis, MD
6:30pm  FACE TO FACE: What Participation Can Mean to
         You and Your Practice
         Ted A. Cook, MD and Harrison C. Putman, III, MD
### TRACK 3 - AESTHETIC AND RECONSTRUCTIVE
*(Grand Ballroom C)*

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>7:30am</td>
<td>Rhinoplasty Panel: My Algorithm for Tip Contouring and Projection</td>
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<td>Moderator: Stephen W. Perkins, MD</td>
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<td>Panelists: Richard E. Davis, MD; Rod Rohrich, MD; and Dean M. Toriumi, MD</td>
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<tr>
<td>8:30am</td>
<td>Featured Speaker: Primary Rhinoplasty--Getting it Right the First Time</td>
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<td>Rod Rohrich, MD</td>
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<td>9:15am</td>
<td>Rhinoplasty Panel: My Three Tips for a Better Nasal Dorsum</td>
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<td>Moderator: Edmund A. Pribitkin, MD</td>
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<td>Panelists: Norman J. Pastorek, MD and Gilbert Nolste Trenité, MD</td>
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<tr>
<td>10:00am</td>
<td><strong>Break and Presentations in the Exhibit Hall</strong></td>
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<tr>
<td>10:30am</td>
<td>Featured Speaker: Rhinoplasty--Tips and Traps</td>
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<td>Bahman Guyuron, MD</td>
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<tr>
<td>11:15am</td>
<td>ABFPRS Awards</td>
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<td>11:30am</td>
<td>Jack Anderson Lectureship</td>
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<td>Michael Super, PhD</td>
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<tr>
<td>12:00pm</td>
<td><strong>Lunch and Presentations in the Exhibit Hall</strong></td>
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<tr>
<td>2:00pm</td>
<td>Rhinoplasty Panel: Conquering the Crooked Nose: Secrets to Success</td>
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<td>Moderator: David W. Kim, MD</td>
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<td></td>
<td>Panelists: Bahman Guyuron, MD; Sam P. Most, MD; and Fred J. Stucker, MD</td>
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<tr>
<td>3:00pm</td>
<td><strong>Break and Presentations in the Exhibit Hall</strong></td>
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### AFTERNOON BREAKOUT SESSIONS

**1:00pm-1:50pm Instruction Courses (IC01-IC06)**

- **IC01** Advances in Secondary Rhinoplasty  
  *Chenier* Rod J. Rohrich, MD
- **IC02** Surgical Treatment of Migraine Headaches  
  *Nottaway* Bahman Guyuron, MD
- **IC03** Maximizing Structural Integrity and Contour  
  *Grand E* Elegance in Tip Rhinoplasty  
  Richard E. Davis, MD
- **IC04** How to Perform an Endoscopic Forehead Lift that Works for the Short and Long Term--It IS in the Technique and Surgical Details  
  Stephen W. Perkins, MD and Heather Waters, MD
- **IC05** The Science of Beauty  
  *Maurepas* Peter A. Adamson, MD
- **IC06** New Techniques and Modifications in Deep Plane Rhytidectomy: A Combined Experience of Over 25 Years  
  Andrew A. Jacono, MD and Neil A. Gordon, MD

**2:00pm-2:50pm Instruction Courses (IC07-IC12)**

- **IC07** Primary Endonasal Rhinoplasty  
  *Maurepas* Norman J. Pastorek, MD
- **IC08** The Male Face: Different Goals for a Different Aesthetic  
  *Chenier* Michael Reilly, MD; Patrick J. Byrne, MD; Babak Azizzadeh, MD; and Monica Tadros, MD
- **IC09** Re-Shaping Our Thinking About the Tip: Static, Dynamic and Vector Modeling Applied  
  *Borgne* Richard Westreich, MD and Minas Constantinides, MD
- **IC10** Fear and Fascination, Love and Loathing: Addressing Patient’s Attitudes Toward Plastic Surgery, The Key to Success  
  *Couteau* James C. Marotta, MD
- **IC11** Managing Your Practice in a Changing Environment  
  *Nottaway* Mark M. Beatty, MD and Brooke Loftis, MD
- **IC12** Is There a Role for the Minimally Invasive Facelift?  
  *Grand E* Paul J. Carniol, MD (moderator); Harry Mittelman, MD; Phillip R. Langsdon, MD; E. Gaylon McCollough, MD; and Fred G. Fedok, MD

**Disclaimer**

Registrants for this course understand that medical and scientific knowledge is constantly evolving and that the views and techniques of the instructors are their own and may reflect innovations and opinions not universally shared. The views and techniques of the instructors are not necessarily those of the Academy or its Foundation but are presented in this forum to advance scientific and medical education. Registrants waive any claim against the Academy or its Foundation arising out of information presented in this course. Registrants also understand that operating rooms and health-care facilities present inherent dangers. Registrants waive any claim against the Academy or Foundation for injury or other damage resulting in any way from course participation. This educational program is not designed for certification purposes. Neither the AAFPRS nor its Foundation provides certification of proficiency for those attending.

The AAFPRS Foundation thanks CareCredit for their non-educational grant.

Instruction course descriptions can be found on pages 20-33.
DAY 1 - SATURDAY, OCTOBER 19, 2013

3:30pm-4:20pm Instruction Courses (IC13-IC19)
IC13 JAMA Facial Plastic Surgery (Oak Alley) Wayne F. Larrabee, Jr., MD and John S. Rhee, MD
IC14 A Comprehensive and Effective Approach for Midfacial Rejuvenation for the 21st Century: An Evidence-Based Approach (Maurepas) Edwin F. Williams, III, MD
IC15 The Middle Vault, the Nasal Valve: Form and Function (Couteau) Fred G. Fedok, MD and Craig S. Murakami, MD
IC16 Mindfulness: A Principle of Tremendous Value to Plastic Surgeons (Nottaway) Jeffrey S. Epstein, MD
IC17 How to Get Predictable Results in Rhinoplasty (Grand E) Dean M. Toriumi, MD
IC18 Forehead Flap Surgery: Lessons Learned from the Master and Applications to Everyday Successful Reconstructions (Borgne) Gary C. Burget, MD and Steven R. Mobley, MD
IC19 Endoscopic Brow Surgery; A Segmental Approach that improves the Predictability of Post-op Results (Chenier) Michael Freeman, MD

5:30pm-6:20pm Instruction Courses (IC27-IC33)
IC27 Repair of Septal Perforations: Classic Techniques and New Innovations (Oak Alley) Ivan Wayne, MD and Steven R. Mobley, MD
IC28 The Socratic Method: Acknowledging the Face has Function (Chenier) Grant S. Hamilton, MD
IC29 Handling Extensive Facial Soft Tissue and Skeletal Injuries (Grand E) Fred G. Fedok, MD; Phillip R. Langsdon, MD; and Krishna Patel, MD
IC30 VIDEO SESSION: Techniques in Facial Reconstruction, Part II (Maurepas) Daniel S. Alam, MD
IC31 Blepharoplasty-Re-Creating the Beautiful Eye (Borgne) Jill Hessler, MD and Gregory H. Branham, MD
IC32 Nasal Augmentation in Ethnic Rhinoplasty Using Custom-Carved Silicone Implants (Couteau) Oleh Slupchynskyj, MD
IC33 Mini-Incision Rhinoplasty: A New ‘Paradigm Shift’ Approach Using Tiny Incisions and Minimal Dissection (Nottaway) Nabil Fanous, MD

4:30pm-5:20pm Instruction Courses (IC20-IC26)
IC20 VIDEO SESSION: Techniques in Facial Reconstruction, Part I (Maurepas) Daniel S. Alam, MD
IC21 New Concepts in Middle Vault and Tip Surgery (Oak Alley) Milos Kovacevic, MD
IC22 Integrating Quality Skincare into Your Facial Plastic Surgery Practice (Nottaway) Lisa Grunebaum, MD and Elizabeth Chance, MD
IC23 Finesse in Revision Rhinoplasty: Pearls and Observations (Couteau) Andrew Frankel, MD
IC24 Nasal Surgery on the Geriatric Patient (Borgne) Stewart C. Little, MD; Fred J. Stucker, MD; and Timothy S. Lian, MD
IC25 Blepharoplasty: Why Transcutaneous Techniques are Still State of the Art (Grand E) Stephen W. Perkins, MD and Jaspreet Prischmann, MD
IC26 Optimum Mobility Facelift: A Revolutionary Approach Using ‘Smart’ Sutures and Minimal Dissection (Chenier) Nabil Fanous, MD

Welcome Reception
Conclude the first day with an opportunity to unwind as you mingle with your colleagues and meet and greet some new ones. The Welcome Reception will be held on Saturday, October 19, 2013 from 6:30pm to 8:00pm in the Exhibit Hall. All registered attendees are invited to attend. Those spouses and guests not registered for the meeting, can purchase a Welcome Reception ticket at the Registration Desk.

The original settlement of New Orleans, called Vieux Carré, French Quarter or simply The Quarter, is the oldest neighborhood in the city. Established by the French in 1718, the location was, and is still, a valuable site for trade due to its strategic position along the Mississippi River.

The district as a whole, bound by Canal Street, Decatur Street, Esplanade Avenue and Rampart Street, is a National Historic Landmark. The French Quarter boasts a storied history of international influence with cultural contributions from the French, Spanish, Italians, Sicilians, Africans, Irish and others - all evident in the development of this global port settlement.
DAY 2 - SUNDAY, OCTOBER 20, 2013

TRACK 1 - NON-SURGICAL (Grand Ballroom D)

Lasers: The New Wavelength
Moderators: Paul J. Carniol, MD and Mitchel Goldman, MD

7:55am Introduction
Paul J. Carniol, MD and Mitchel Goldman, MD
8:00am Laser Treatment of Vascular and Pigmented Lesions
Mitchel Goldman, MD
8:10am Laser Treatments in Patients with Fitzpatrick IV-VI
Kristina Zakhary, MD
8:20am Optimizing Pre and Post-Treatment Care of Laser Patients
Jill Hessler, MD
8:30am RF, The New Non-laser Wavelength for Minimally Invasive Skin Tightening and Nerve Ablation
Gregory S. Keller, MD
8:40am Laser Safety and Complications
Jason Bloom, MD
8:50am Fractional CO₂ Lasers and Skin Tightening
Paul J. Carniol, MD
9:00am Combining Laser and Light Frequency
Ryan Greene, MD
9:10am Use of 3D Laser Subcision for the Treatment of Acne
Richard D. Gentile, MD
9:20am Glass and Erbium: YAG Lasers as a Tool in Scar Revision
Andrew Winkler, MD
9:30am Laser Treatment of Melasma
Mary Lupo, MD
9:40am Practical Solutions with Light-based Devices
Jason Pozner, MD

10:00am Break and Presentations in the Exhibit Hall

10:30am Laser Treatment of Blue Veins
David A.F. Ellis, MD
10:40am Laser Treatment of Scars
Kate McCarn, MD
10:50am Post Resurfacing Care: Minimizing Complications
Kevin Duplechain, MD
11:00am The 4 Week Challenge
Andrew C. Campbell, MD
11:10am How to Maximize Results with CO₂
Jacob Steiger, MD
11:20am Treatment of Acne and Associated Scarring
Ryan Greene, MD
11:30am CME Program Adjourned

Lumenis Symposium (Non-CME)
11:30am Advances in Fractionated CO₂ Laser Resurfacing
Mitchel Goldman
12:00pm Incorporating Laser Hair Removal and IPL into a Practice
Mary Lupo, MD

(The AAFPRS wishes to thank Lumenis for their non-educational grant.)

12:00pm Lunch and Presentations in the Exhibit Hall

More Than Skin Deep
Moderator: Terri Wojak

1:00pm Combining Skincare with Cosmetic Medicine
Terri Wojak
1:15pm Essential Skincare Items My Patients Can’t Live Without
Heidi Waldorf, MD
1:30pm Platelet Rich Plasma for Skin Rejuvenation
Norman J. Pastorek, MD
1:45pm My Experience with Medical Skincare
Raj TerKonda, MD
2:00pm The Top Five Ingredients Every Patient Needs in their Regimen
Jennifer Linder, MD
2:15pm Chemical Peeling in a Modern Era
Phillip R. Langsdon, MD
2:30pm Antioxidants and Their Uses with Lasers
Julie Woodward, MD

3:00pm Break and Presentations in the Exhibit Hall

Emerging Technology and Hot Topics
Moderator: Andrew C. Campbell, MD

3:30pm Enhancing Results through Injectable Fat Reduction
Heidi Waldorf, MD
3:40pm Topically Driven: Botulinum Toxin without the Needles
John Joseph, MD
3:50pm Stem Cells and Facial Plastic Surgery
William H. Beeson, MD
4:00pm Bioidentical Hormone Therapy
Robert Shumway, MD
4:10pm Cold Nerve Ablation
Jonathan M. Sykes, MD
4:20pm Non-Surgical Skin Tightening: Face the Truth
Andrew C. Campbell, MD
4:30pm Benefits of PRP
Gregory S. Keller, MD
4:40pm 3D Laser Fiber and Treatment of Cellulite
Richard D. Gentile, MD, MBA
4:50pm Resurfacing with Portrait Plasma
Jefferson Kilpatrick, MD
5:00pm Submental Laser Lipolysis Under Local without IV Sedation
Adam Schaffner, MD
5:10pm Panel: Neurotoxins Science
Moderator: Steven H. Dayan, MD
Panelists: Jurgen Frevert (Merz); Andy Pickett (Valeant); and Conor Gallagher (Allergan)

6:00pm-7:00pm Live Injections
Mary Lupo, MD and Kevin Duplechain, MD
(The AAFPRS wishes to thank Merz Aesthetics for their educational grant.)
DAY 2 - SUNDAY, OCTOBER 20, 2013

TRACK 2 - PRACTICE MANAGEMENT (Grand Ballroom B) (Non-CME)

10:00am Break and Presentations in the Exhibit Hall

Can I Reach an External Market While Keeping Costs Low?
Moderator: Greg Washington

10:30am Word-of-Mouth Marketing
Tracy Drumm

10:45am Webonomics
Robert Baxter

11:00am Groupon: Illegal Fee Splitting or Strategic Marketing Tool
Alex Thiersch

11:15am Media Marketing on a $0 Budget
Jess Prischmann, MD

11:30am Goldmine with Patient Webinars
Catherine Maley

11:45am Patient Loss Prevention with Smart Internet Marketing
Greg Washington

12:00pm Lunch and Presentations in the Exhibit Hall

What are the ROI's of Social Media?
Moderator: Tom Seery

1:00pm How to Get Real ROI from Social Media
William Portuese, MD

1:15pm The SEO ROI's from Social Media
Greg Washington

1:30pm Dealing with Difficult Patients in a Digital Age
Donn R. Chatham, MD

1:45pm The Real Deal
Tom Seery

How Do I Protect Myself Against Upset Patients and Bad Reviews?
Moderator: Brent Koch, MD

2:00pm Taming the Lions--Advanced Concepts on Overcoming Top 10 Patient Objections
Jon Hoffenberg

2:15pm Your Real Malpractice Premium: Communication with Patients in Difficult Situations
Brent Koch, MD

2:30pm Web Protection Strategies
Robert Baxter

2:45pm Reputation Management: Bulletproofing Your Practice
Donn R. Chatham, MD

3:00pm Break and Presentations in the Exhibit Hall

Can I Get a Lawyer's Perspective?
Moderator: David Mandell, JD, MBA

4:30pm Corporate Structure/Tax Reduction
David Mandell, JD, MBA

4:45pm New Requirements for Business Associate Agreements
Mike Sacopulos, JD

5:00pm Panel: Legal Matters
David Mandell, JD; Michael Sacopulos, JD; and Alex Thiersch, JD

Financial Planning
5:30pm Strategies for a Deleveraging World: Investment, Financial Planning, and Tax Management
Hobart Porter, CFP
DAY 2 - SUNDAY, OCTOBER 20, 2013

TRACK 3 - AESTHETIC  (Grand Ballroom C)

Facelift: Many Techniques, One Outcome, Part I
Moderator: Andrew A. Jacono, MD

8:00am  Progressive Approach to Facial Aging
Mark M. Beaty, MD

8:10am  Planning Facial Rejuvenation
Jacob Steiger, MD

8:20am  The Modern Minimally Invasive Facelift
Andrew A. Jacono, MD

8:30am  Technique for Endoscopic Mid Face Lifting
Thomasromo, III, MD

8:40am  High SMAS Technique
Paul Leong, MD

8:50am  Extended Deep Plane Rhytidectomy
Andrew Frankel, MD

9:00am  Appropriate Indications and Technique for Neck Liposuction
S. Randolph Waldman, MD

9:10am  SMAS Deep Facelift with Submental Work
Andrew C. Campbell, MD

9:20am  Laser Assisted Facelifts
Edmon Khoury, MD

9:30am  Face and Neck Lifting: A “No Nonsense” Approach
Stephen W. Perkins, MD

9:40am  Practical Application of The McCollough Facelift Classification System
E. Gaylon McCollough, MD

10:00am  Break and Presentations in the Exhibit Hall

Facelift: Many Techniques, One Outcome, Part II
Moderator: Neil A. Gordon, MD

10:30am  Purse String Face Lifting
Laxmeesh Mike Nayak, MD

10:40am  How I Do Procedures Including Deep Plane Face Lift Under Local
Edmon Khoury, MD

10:50am  Nuances of Deep Plane Rhytidectomy: 17 Years
Neil A. Gordon, MD

11:00am  Mini Facelift with Maximum Results Under Local
Adam Schaffner, MD

11:10am  Revision Facelift
Amir Moradi, MD

11:20am  Minor Revisions In Facelift Surgery/Submentoplasty
Jefferson Kilpatrick, MD

11:30am  Contemporary Use of Extended Silastic Chin Implants
S. Randolph Waldman, MD

11:40am  Which Procedure for Which Patient
Jonathan M. Sykes, MD

11:50am  Evaluation of Fibrin Sealant and Postoperative Hematoma/Seroma Rates in Rhytidectomy
Ronald J. Caniglia, MD and Taylor R. Pollei, MD

12:00pm  Lunch and Presentations in the Exhibit Hall

Browlift
Moderator: Laxmeesh Mike Nayak, MD

1:00pm  A Simplified Approach to Endobrow
Laxmeesh Mike Nayak, MD

1:15pm  Multimodality Brow Rejuvenation: It’s Not Just Endolift
Donn R. Chatham, MD

1:30pm  Back to the Future: Surgery of the Periocular Area: Midface and Brow
Gregory S. Keller, MD

1:45pm  A Comprehensive Approach to Midface Rejuvenation
Edwin F. Williams, III, MD

2:00pm  Masters Panel: Minimizing, Recognizing and Treating Complications in Facelift Surgery
Moderator: William H. Truswell, MD
Panelists: Shan R. Baker, MD; Keith A. Laferriere, MD; Devinder S. Mangat, MD; Harrison C. Putman, MD

3:00pm  Break and Presentations in the Exhibit Hall

Blepharoplasty
Moderator: Julie Woodward, MD

3:30pm  Decision Making in Blepharoplasty: Developing an Individualized Diagnosis and Treatment Plan
Robert A. Goldberg, MD

4:00pm  New Insights into Fat Transposition of Lower Blepharoplasty
Guy Massry, MD

4:20pm  Blepharoplasty: The No Touch Technique
Adam Schaffner, MD

4:40pm  SOOF Lift Blepharoplasty
Michael Freeman, MD

5:00pm  Panel: What will Facelifts Look Like In 2025?
Moderators: Vito C. Quatela, MD and Jacob Steiger, MD
Panelists: Andrew A. Jacono, MD; Neil A. Gordon, MD; Thomas Romo, III, MD; and Edwin F. Williams, III, MD

The AAFPRS Foundation thanks Allergan for their non-educational grant.
TRACK 4 - RECONSTRUCTIVE  (Grand Ballroom A)

7:30am  Panel: Nasal Reconstruction—Small to Medium Defects, No Forehead Flaps Allowed
Moderator: William W. Shockley, MD
Panelists: Brian Jewett, MD; Jeff Moyer, MD; and Jeffrey Spiegel, MD

8:30am  Featured Speaker: Aesthetic Reconstruction of the Nose
Gary C. Burget, MD

9:15am  Panel: Nasal Reconstruction—Complex and Composite Defects, When a Forehead Flap is Just not Enough
Moderator: Shan R. Baker, MD
Panelists: Gary C. Burget, MD and Stephen S. Park, MD

10:00am  Break and Presentations in the Exhibit Hall

10:30am  Featured Speaker: Revision Surgery Following Nasal Reconstruction: Tips on Prevention and Useful Revision Techniques
Shan R. Baker, MD

11:00am  AAFPRS Grants/Awards
11:10am  Outgoing Presidential Address
11:30am  John Conley Lectureship
David M. Buss, PhD

12:00pm  Lunch and Presentations in the Exhibit Hall

1:00pm  Panel: Surgical Pearls in Microtia Surgery
Moderator: Craig S. Murakami, MD
Panelists: Jennifer Kim, MD; Bryan Ambro, MD; Thomas Romo, III, MD; and Tom D. Wang, MD

2:00pm  Panel: Pediatric Facial Plastic and Reconstructive Surgery—Challenges and Controversies
Moderator: Sherard A. Tatum, MD
Panelists: Krishna Patel, MD; Travis Tollefson, MD; and Tom D. Wang, MD

2:00pm  Free Paper Presentations (see page xx for schedule)

3:00pm  Break and Presentations in the Exhibit Hall

3:30pm  Panel: Optimizing Reimbursement for Reconstructive Surgery
Moderator: Daniel S. Alam, MD
Panelists: Bryan Ambro, MD; Jennifer Kim, MD; Steven R. Mobley, MD; and Michael Nuara, MD

AFTERNOON BREAKOUT SESSIONS

1:00pm-1:50pm Instruction Courses (IC34-IC40)
IC34  Nasal Valve Repair: A Structurally Integrated Approach
Maurepas
J. Madison Clark, MD and Ted A. Cook, MD

IC35  Rhinoplasty in Wegener’s Granulomatosis: An Update on Workup, Treatment and Surgical Care
Oak Alley
Andrew Winkler, MD and Adam Terella, MD

IC36  Advanced Dynamic Grafting in Functional Rhinoplasty
Grand E
Benjamin C. Marcus, MD

IC37  Acne Rosacea: The Red Face
Chenier
David A.F. Ellis, MD

IC38  Prevention and Management of DVT and PE within an Office Based Surgical Facility
Nottaway
J. Kevin Duplechain, MD

IC39  Management of Hemangiomas and other Vascular Anomalies
Borgne
Marcelo Hochman, MD

IC40  Pricing Strategy for Facial Plastic Surgery Practices
Couteau
Karen Zupko

3:30pm-4:20pm Instruction Courses (IC41-IC47)
IC41  Advanced Surgical Approaches to Vascular Malformations and Hemangiomas to the Face and Neck in Infants and Children
Maurepas
Edwin F. Williams, III, MD

IC42  Optimal Application of Computer Imaging For the Rhinoplasty Patient
Couteau
Behrooz A. Torkian, MD and Andrew S. Frankel, MD

IC43  Systematic Reviews for Facial Plastic Surgeons: Pearls and Pitfalls
Oak Alley
Lisa Ishii, MD and Travis Tollefson, MD

IC44  The Shrink Wrap Facelift: Combining Laser Resurfacing with Fat Grafting and Facelift Surgery
Nottaway
J. Kevin Duplechain, MD

IC45  Finesse with Fillers and Neurotoxins
Grand E
Theda C. Kontis, MD

IC46  Newer Approaches and Techniques to Improve Efficiency in Facial Trauma Surgery
Chenier
Amar Suryadevara, MD

IC47  Improving Results In Facial Scar Treatment
Borgne
J. Regan Thomas, MD and David B. Hom, MD

Instruction Courses, Continued ...

Instruction course descriptions can be found on pages 20-33.
DAY 2 - SUNDAY, OCTOBER 20, 2013

4:30pm-5:20pm Instruction Courses (IC48-IC54)
IC48 How to Make a Beautiful Nose Functional (Oak Alley) Norbert Gorski, MD
IC49 Alloplasts in Rhinoplasty: What’s New and What’s Safe (Borgne) Andrew Winkler, MD
IC50 Current Trends and Contemporary Refinements in Facial Fillers (Maurepas) Babak Azizzadeh, MD; Guy G. Massry, MD; and Donald B. Yoo, MD
IC51 Straightening the Crooked Nose (Chenier) Ivan Wayne, MD and Douglas M. Sidle, MD
IC52 Surgery For Migraines: An Opportunity for the Facial Plastic Surgeon (Nottaway) Marcelo Hochman, MD
IC53 Salvage Rhinoplasty Surgery for the Severely Deformed Nose (Grand E) Russell W.H. Kridel, MD
IC54 Nasal Base Surgery: Indications, Techniques, Complications, Secrets (Couteau) Alireza Mesbahi, MD

5:30pm-6:20pm Instruction Courses (IC55-IC61)
IC55 Management Strategies for Nasal Valve Obstruction (Borgne) Stephen Goldstein, MD and Oren Freidman, MD
IC56 Coding and Documentation for the Facial Plastic and Reconstructive Surgeon (Oak Alley) P. Daniel Ward, MD and Krishna Patel, MD
IC57 Management of Septal Perforations (Chenier) Stephen F. Bansberg, MD and Andrew Courson, MD
IC58 Muscle Tendon Unit Transfer for Facial Reanimation (Couteau) Kofi D. Boahene, MD
IC59 Seven Critical Steps: The Crooked Nose Algorithm (Maurepas) Benjamin C. Marcus, MD and Travis Tollefson, MD
IC60 Comprehensive Perioral Rejuvenation: Augmentation, Resurfacing and Neurotoxins—What are the Options? (Grand E) John Birner, MD; Steven R. Mobley, MD; and Jaspreet Prischmann, MD
IC61 Social Media Boot Camp for Facial Plastic Surgeons (Nottaway) Wendy Lewis and Denise Mann

WORKSHOP (Rhythms 1)
Third Annual Advances in Microvascular Surgery
8:00am-12:30pm (For non-registered physicians, the cost for this workshop is $150.)
8:00am-8:10am Introduction and Reflections Mark Wax, MD

Session 1
Moderator: Mark Wax, MD
8:10am-8:25am Current Concepts in Maxillary Reconstruction Daniel P. Knott, MD
8:25am-8:40am What to do When that First Flap Fails Mark Wax, MD
8:40am-9:05am Great Debate 1: Facial Rehabilitation: Gracilis vs. Dynamic Reconstruction Chad Zender, MD vs. Babak Azizzadeh, MD
9:05am-9:20am Update in Allograft Transplantation Daniel S. Alam, MD
9:20am-9:45am Great Debate 2: Reconstruction of the Lateral Mandibular Defect Osteo Flap vs. Plate and Flap Lisa Shnayder, MD vs. Michael Nuara, MD

Session 2
Moderator: Daniel P. Knott, MD
9:45am-10:00am Microvascular Surgery in the Vessel Depleted Neck Eric Genden, MD
10:00am-10:10am Laryngo Tracheal Reconstruction Amy Pittman, MD
10:10am-10:20am Robotics and Flaps Tamer Ghanem, MD
10:20am-10:50am Break and Discussion

Session 3
Moderator: Eric Genden, MD
10:50am-11:20am Quality of Life, Patient Measured Outcomes and Optimizing Speech and Swallowing Steve Cannady, MD; Alexander Langerman, MD; and Eric Lamarre, MD
11:20am-11:45am Great Debate 3: Perforator vs. Non Perforator Flaps Douglas Chepeha, MD vs. Matt Hanasono, MD
11:45am-11:55am Free Tissue Transfer in the Management of Trauma Rod Rezaee, MD
11:55am-12:05pm Free Flaps in the Elderly Robert Lindau, MD
12:05pm-12:15pm Controversies in Post Operative Management Mathew Miller, MD
12:15pm-12:25pm The Role of 3D Modeling in Maxillo-Mandibulo Reconstruction Brett Miles, MD
12:25pm-12:30pm Free Tissue Transfer for Lower Lip Reconstruction Amit Bhrany, MD

The AAFPRS Foundation thanks DePuy Synthes for their educational grant.
**DAY 3 - MONDAY, OCTOBER 21, 2013**

**TRACK 1 - NON-SURGICAL** *(Grand Ballroom D)*

**Facial Plastic Surgery: A Different Translation**  
Moderator: Wayne F. Larrabee, Jr., MD

8:00am  **My Favorite Rhinoplasty**  
Roxana Cobo, MD

8:15am  **Use of Old Local Steroid in Septorhinoplasty**  
Alirea Mesbah, MD

8:30am  **Liquid Facelift: The Fafi Grid**  
Dario Bertossi, MD

8:45am  **Rhinoplasty of the Thin Skin Patients--Avoiding Problems with North Eastern Patient Population**  
Norbert Gorski, MD

9:00am  **Facial Plastic Surgery: The Asian Experience**  
Hyoung Jin Moon, MD

9:15am  **Keystone Area Revisited**  
Fazil Apaydin, MD

9:30am  **Brazilian Rhinoplasty: Where We are and Where We are Going**  
Josea Patrocino, MD

10:00am  **Break and Live Auction Finale in the Exhibit Hall**

**AAFPRS Research**

10:30am  **AAFPRS Research Center Update**  
Sam P. Most, MD

10:40am  **Best Clinical Research Practices**  
Amir Moradi, MD

11:00am  **Good Clinical Practices**  
Misty D'Ottavio, Senior Manager, Regulatory Affairs, Merz Pharmaceuticals

Good Clinical Practices covers all aspects of clinical research, including design of the trial, its conduct, data recording, and data reporting.

11:20am  **So you want to be a PI (Principal Investigator)?**  
Leslie Humphries, Head of Clinical Operations, Merz Pharmaceuticals

This topic will cover site qualifications, resource allocation, and sponsor relationships.

11:40am  **Investigator Initiated Studies: An introduction**  
Jeanette Moradi-Poehler, Clinical Research Coordinator

This lecture will briefly touch on protocol design, IRB submission, and publication.

12:00pm  **Lunch and Canfield Contest in the Exhibit Hall**

**Canfield VECTRA® 3D Face Off**  
Presented by: Tiffany Nelson

Physician member attendees are invited to try their hand at creating VECTRA 3D simulations of two different procedures, rhinoplasty and facial rejuvenation. Canfield will provide VECTRA 3D images of the pre-op patients, and, using Face Sculptor 3D aesthetic simulation tools, the contestant will perform the virtual procedure. A distinguished panel of judges will select the most compelling result in each category. Winners will be presented with awards at the conclusion of the event which is on Monday, October 21, 2013 at 12:00pm in the Exhibit Hall.

**TRACK 2 - PRACTICE MANAGEMENT** *(Non-CME)* *(Grand Ballroom B)*

**I've Finished Training, Now What?**  
Moderators: Sunny Park, MD and Taha Shipchandler, MD

The AAFPRS thanks Medicis for their non-educational grant.

8:00am  **Contract Negotiations**  
Greg Wikelius

8:30am  **A Guide to Your First Year After Fellowship**  
Sunny Park, MD

8:45am  **Transitions Following Training**  
Andrea Jarchow, MD

9:00am  **Career Option Pros and Cons**  
Kimberly Lee, MD

9:15am  **My First Year of Start Up in Private Practice**  
Bob Brobst, MD

9:30am  **First Year In Private Practice, Lessons Learned**  
Kimberly Donnellan, MD

9:45am  **Joining an Established Private Practice**  
Anthony Bared, MD

10:00am  **Break and Live Auction Finale in the Exhibit Hall**

10:30am  **Starting Your Practice Off Right**  
Waleed Ezaat, MD

10:45am  **Joining A Dermatology Practice**  
Jason Bloom, MD

11:00am  **Starting An Academic Practice**  
Taha Shipchandler, MD

11:15am  **Joining and Managing a Multispecialty Practice**  
Jason Meier, MD

11:30am  **Strategies for Success: Contract Negotiations and Financial Planning**  
Greg Wikelius

12:00pm  **Lunch and Canfield Contest in the Exhibit Hall**

**TRACK 3 - AESTHETIC** *(Grand Ballroom C)*

**Panel: Otoplasty--Management of Congenital, Age Related and Acquired Ear Deformities**  
Moderator: Edward H. Farrior, MD

Panelists: Peter A. Adamson, MD; Peter A. Hilger, MD; and Steven R. Mobley, MD

8:00am  **Panel: Fat Transfer--An Idea Posed**  
Moderator: Samuel M. Lam, MD

Panelists: Mark A. Glasgold, MD and Laxmeesh Mike Nayak, MD

The AAFPRS thanks Restoration Robotics for their educational grant.

9:00am  **Panel: Otoplasty--Management of Congenital, Age Related and Acquired Ear Deformities**  
Moderator: Edward H. Farrior, MD

Panelists: Peter A. Adamson, MD; Peter A. Hilger, MD; and Steven R. Mobley, MD

Track 3, Continued...
DAY 3 - MONDAY, OCTOBER 21, 2013

10:00am Break and Live Auction Finale in the Exhibit Hall

10:30am Panel: Here Today, Hair Tomorrow
Why We Do It and Why You Should Too
Perspective from Six Surgeons
Moderator: Jeffrey S. Epstein, MD
Panelists: John Bitner, MD; Anthony Bared, MD; Lisa Ishii, MD; Gorana Kuka, MD; and Samuel M. Lam, MD

12:00pm Lunch and Canfield Contest in the Exhibit Hall

TRACK 4 - RECONSTRUCTIVE (Grand Ballroom A)

7:30am Panel: Challenging Cases in Facial Reconstruction--
Tumors and Trauma
Moderator: Mark Wax, MD
Panelists: Lawrence Marentette, MD and Daniel S. Alam, MD

8:15am Featured Speaker: Tricks of the Trade: Rethinking
Mohs Reconstruction, Plus Update on Mohs and Melanoma
Tri Nguyen, MD

9:00am Panel: Challenging Cases In Reconstruction of Facial
Defects--Face, Lip and Ear
Moderator: Stephen S. Park, MD
Panelists: Patrick J. Byrne, MD; Craig S. Murakami, MD; and Tri Nguyen, MD

10:00am Break and Live Auction Finale in the Exhibit Hall

10:30am Business Meeting and Elections
Incoming Presidential Address

11:30am Gene Tardy Scholar
Peter A. Adamson, MD

12:00pm Lunch and Canfield Contest in the Exhibit Hall

1:00pm Masters Rhinoplasty Panel: Challenging Cases--I Bet
I Know What You Did...But This Is What I Would Have Done
Moderator: Peter A. Adamson, MD
Panelists: E. Gaylon McCollough, MD; Vito C. Quatela, MD; Robert L. Simons, MD; and J. Regan Thomas, MD

2:15pm Panel: Experience, Science and Nasal Valve Surgery--
What the Literature Does Not Tell Us
Moderator: Minas Constantinides, MD
Panelists: Madison Clark, MD; Benjamin Marcus, MD; Steven R. Mobley, MD; and Ira D. Papel, MD;

AFTERNOON BREAKOUT SESSIONS

2:00pm-2:50pm Instruction Courses (IC62-IC68)
IC62 Otoplasty: A Simple Technique for the Protruding
(Maurepas) Ear
Sunny Park, MD and Fred J. Stucker, MD

IC63 When Less is More and More is Less in Mohs
(Grand E) Reconstruction
Tri Nguyen, MD

IC64 Nerve Grafting and Nerve Transfer Techniques for
(Oak Alley) Dynamic Facial Reanimation
Kofi Boahene, MD

IC65 Structural Grafting of the Lower Third of the Nose
(Borgne) Fred G. Fedok, MD

IC66 Facial Plastic Surgery Emergencies: Recognition,
(Chenier) Management and Prevention of Complications
Sydney C. Butts, MD; Theda C. Kontis, MD; Laura Hetzler, MD; and Krishna Patel, MD, PhD

IC67 Precision in Rhinoplasty
(Couteau) Roxana Cobo, MD and Gilbert Nolst Trenité, MD

IC68 Profile Alignment
(Nottaway) Fazil Apaydin, MD

3:00pm-3:50pm Instruction Courses (IC69-IC75)
IC69 Laser Assisted Facelift
(Maurepas) David Holcomb, MD

IC70 Personal Tips for Successful Management of
(Grand E) Difficult Noses
Yong Ju Jang, MD

IC71 Surgery of the Nasal Valves: Optimizing Outcomes
(Chenier) for Nasal Obstruction
Amar Suryadevara, MD and Parul Goyal, MD

IC72 Concepts, Analysis and Techniques in African
(Oak Alley) American Rhinoplasty
Kofi Boahene, MD and Ife Sofola, MD

IC73 Medical Statistics for the Facial Plastic Surgeon:
(Nottaway) What You Need to Know
Craig Czyz, MD

IC74 Raving Patients! A System of Practical, Research-
(Borgne) Based Techniques for Improving Healthcare
Provider-Patient Communication and Outcomes
Brent Koch, MD

IC75 Microvascular Surgery for the Facial Plastic Surgeon
(Couteau) Daniel P. Knott, MD and Rahul Seth, MD

4:00pm-4:50pm Instruction Courses (IC76-IC81)
IC76 The Endoscopic Subperiosteal Midface Lift: Pearls,
(Maurepas) Pitfalls, Step by Step Technique
Anurag Agarwal, MD and Richard P. Maloney, MD

IC77 New Approaches to Periorbital Rejuvenation
(Grand E) Richard D. Gentile, MD

IC78 Short Flap/Modified Face Lifting Procedure Using
(Nottaway) Level 1 Local Anesthesia in an Office Setting
John A. Standefer Jr., MD and Jason Swerdloff, MD

IC79 Why Should I Pay More for My Internet Marketing
(Borgne) Strategy? (Non-CME)
David Evans, PhD

IC80 Cartilage Repositioning Rhinoplasty: An Extension
(Chenier) of the Tripod/Pedestal Concept
Howard D. Stupak, MD

IC81 Treatment and Reconstruction of Advanced Basal
(Couteau) Cell Carcinoma of the Face
P. Daniel Knott, MD and Rahul Seth, MD
The following is the schedule of the free paper presentations for Sunday, October 20, 2013 from 2:00pm to 3:00pm. There are seven (7) sessions/rooms occurring concurrently. Their abstracts are printed on pages 34–54.

Room 1: Aging Face (Maurepas)
2:02pm An Analysis of Factors Contributing to Post-Blepharoplasty Lower Lid Retraction
Garrett Griffin, MD
2:10pm Current Trends in Upper and Lower Lid Blepharoplasty: A National Survey of AAFPRS Members
Grace Lee Peng, MD
2:18pm Endoscopic Forehead Lift: Experience Over an 18-Year Period
Heather H. Waters, MD
2:26pm Refining the Results of Aging Face Surgery with Hair Transplantation Techniques
Gorana Kuka, MD
2:34pm Customizable Facial Implants Utilizing 3D CT Imaging and Internet Peer-to-Peer Networking Protocol without the Need for Physical Modeling
Karan Dhir, MD and William Binder, MD
2:42pm Objective Assessment of Perceived Age Reversal and Improvement in Attractiveness After Aging Face Surgery
Milad Modabber, MD

Room 2: Aging Face (Borgne)
2:02pm Redefining Relationships in the Mid-Face: New Concepts for the Surgical Anatomy of the SMAS, Deep Fascia, the Facial Nerve, and Muscles
Chiara Andretto Amodeo, MD
2:10pm Deep-Plane Rhytidectomy in Smokers
David Q. Santos, MD
2:18pm Sub SMAS Mobilization and Division with Significant Advantages in SMAS Advancement and Neck Contouring
Douglas W. Halliday, MD
2:26pm Efficacy of Artiss in Rhytidectomy: A Prospective Randomized Study
Lindsay S. Eisler, MD
2:34pm Quantitative Assessment of the Role of Sculptra Aesthetic in Mid-facial Rejuvenation
Pardis Javadi, MD
2:42pm The Aesthetic Unit Principal of Facial Aging
Michael Brandt, MD

Room 3: Minimally invasive & Laser (Oak Alley)
2:02pm Low Level Laser Light Therapy for Hair Loss: Analysis of Patient Survey
Anthony Bared, MD
2:10pm Black Light Assessment of Surgical Trainees for Facial Reconstruction
Javad Sajan, MD
2:18pm Multicentre Study for Acute Resurfacing Wound Care with Hypochlorous Acid Solution
Basil Hassouneh, MD
2:26pm Pre-made Fixation Plates for the Endoscopic Assisted Transoral Approach to Orbital Rim Fractures
Todd M. Brickman, MD
2:34pm Plastic Surgery Digital Photograph Management Using Adobe Lightroom
William E. Walsh, MD
2:42pm A Comparison of the Rheological Properties of an Adipose Extracellular Matrix Biomaterial and Aspirated Adipose Tissue
Amit Kochhar, MD

Room 4: Reconstruction (Nottaway)
2:02pm Decompression and Transposition of the Intratemporal Facial Nerve to a Hypoglossal Nerve with Partial Neurotomy for Reanimation of the Paralyzed Face
Amit Kochhar, MD
2:10pm Mucosal Flap Repair of 163 Septal Perforations
Andy M. Courson, MD
2:18pm Vascularized Fibular Flaps in the Reconstruction of Large Pediatric Mandibular Defects Following Tumor Ablation
James Owusu, MD
2:26pm In Vivo Long-Term Viability and Shape Change of Costal Cartilage Following Electromechanical Cartilage Reshaping in the New Zealand White Rabbit-Optimization
Karam Badran, MD
2:34pm Reconstruction of Facial Skin Defects with Split-Thickness Skin Grafts from the Scalp
Matthew Voorman, MD
2:42pm Current Practice Patterns for Prescribing Antibiotics for Facial Fractures: Preliminary Results
Neerav Goyal, MD

Room 5: Reconstruction (Grand Chenier)
2:02pm Endoscope Assisted Treatment of Subcondylar Fractures Using a Transoral Approach
Todd M. Brickman, MD
2:10pm The Learning Curve in Head and Neck Microvascular Surgery After Fellowship
Steven B. Cannady, MD
2:18pm Ultrathin Silicon Sheet in the Management of Post-traumatic Temporo-mandibuar Joint Ankylosis in Children – A Good Alternative to Conventional Techniques
Ankur Bhatnagar, MD
2:26pm Systematic Review of Free Flap Options for Mandibular Reconstruction and a Preliminary Quality of Life Comparison
Sami P. Moubayed, MD
2:34pm Systematic Review of Outcome Measure Reporting after Microvascular Head and Neck Reconstruction of the Oral Cavity and Oropharynx
Eric Lamarre, MD
2:42pm Increased Survival of Human Adipose Derived Stem Cells in the Presence of BMP-2
Brian Lawton, MD

Continued ...
### FREE PAPERS

#### Room 6: Rhinoplasty (Grand Couteau)
- 2:02pm Temporalis Fascia vs Surgisis Graft for Repair of Septal Perforation
  - Basil Hassouneh, MD
- 2:10pm Formation of the Inverted V Deformity: A Finite Element Model Simulation
  - Tjoson Tjoa, MD
- 2:18pm The Tripod Cartilage Repositioning Procedure to Achieve Improved Tip Rotation and Nasal Function Using The Alar™ Stent Device
  - Stefan W. Shuaib, MD
- 2:26pm Nasal Osteotomies: A Cadaveric Study of Fracture Lines
  - Nathalie Gabra
- 2:34pm Microbiology and Antibiotic Prophylaxis in Rhinoplasty: A Review of 363 Consecutive Cases
  - Donald Yoo, MD

#### Room 7: Rhinoplasty (Grand E)
- 2:02pm Rhinoplasty Litigation: Trends, Pitfalls and Financial Burden--A 25 Year Review
  - Jared R. Seibert
- 2:10pm The Underlying Relationship of the Upper Lateral Cartilage with the Piriform Aperture
  - John R. Craig, MD
- 2:18pm Development of a Severity Classification System for Subjective Nasal Obstruction
  - Michael J. Lipan
- 2:26pm Surgical Approach to Nasal Obstruction in Patients with Sleep-Disordered Breathing Using Functional Rhinoplasty and Drug-induced Sleep Endoscopy
  - Amy L. Richter, MD
- 2:34pm Evaluation of Nasal Valve Obstruction in Functional and Functional--Aesthetic Rhinoplasty Patients
  - Basil Hassouneh
- 2:42pm The Surgical Hairline Advancement/Forehead Shortening Procedure--An Effective One-Stage Technique for Lowering the Overly High Female Hairline
  - Jeffrey S. Epstein, MD

### EXHIBIT HALL PRESENTATIONS (Non-CME)

#### Saturday, October 19, 2013
- **Morning Break 10:00-10:30am**
  - CEATUS Media Group LLC
  - SEO Strategies for Premier Plastic Surgery Practices
    - David Evans, PhD, Ceatus Media Group CEO
- **Lunch Break 12:00-12:30pm**
  - RESTORATION ROBOTIC
  - Robotic Hair Transplantation with the ARTAS® System
    - Miguel Canales, MD
- **Lunch Break 12:30-1:00pm**
  - CEATUS Media Group LLC
  - ‘Your Website: Does it Convert? Does it Rank?’
    - David Evans, PhD, Ceatus Media Group CEO
  - Key components of an effective practice Web site will be identified, including attractive image, effective marketing message, prominent call to action, search engine friendly and mobile friendly.

#### Sunday, October 20, 2013
- **Morning Break 10:00-10:30am**
  - ELLMAN International, Inc.
- **Lunch Break 12:00-1:00pm**
  - CEATUS Media Group LLC
  - ‘Maximizing Your Online Marketing ROI’
    - David Evans, PhD, Ceatus Media Group CEO
  - A detailed description of the components of an effective online marketing strategy will be discussed. Topics to be addressed include: key components of website design; overview of online visibility strategies, including PPC, SEO and Google+; Google Authorship; reviews and reputation management; and responsive Web design.

#### Monday, October 21, 2013
- **Morning Break 10:00-10:30 am**
  - Live Auction Finale
- **Lunch Break 12:00 -1:00pm**
  - Canfield Contest Finale
INSTRUCTION COURSES 1-6

IC01 Advances in Secondary Rhinoplasty (Chenier)
Rod J. Rohrich, MD
Summary: Delineate the causes, pathogenesis and how to prevent secondary nasal deformities in rhinoplasty. The goal will be to emphasize the 10 principles of preventing a secondary nasal deformity and what patients are predisposed to these deformities.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) analyze a complex nasal deformity; 2) recognize the pitfalls of a difficult nose (i.e. short nasal bones, high dorsal septal deviation, weak alar rims and thin skin; 3) prevent secondary nasal deformities; 4) manage the secondary nasal deformity patient; and 5) learn methods to correct secondary nasal deformities

IC02 Surgical Treatment of Migraine Headaches (Nottaway)
Bahman Guyuron, MD
Summary: Migraine headache is a chronic, often incapacitating condition that afflicts approximately 28 million Americans (12% of the population), disproportionately affecting more females (18%) than males (6%). Despite its prevalence, this condition remains largely under diagnosed and under treated. This course will provide in-depth information about surgical or chemical (Botox) deactivation of migraine trigger points as an isolated procedure or in conjunction with other aesthetic and reconstructive procedures.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) identify symptoms of migraine headaches; 2) discuss the constellation of symptoms that aid in identifying the migraine trigger site; and 3) explain the potential pathophysiology of each trigger sites.

IC03 Maximizing Structural Integrity and Contour Elegance in Tip Rhinoplasty (Grand E)
Richard E. Davis, MD
Summary: Achieving a durable and attractive nasal tip contour with excisional rhinoplasty techniques is often difficult. Although cartilage excision can achieve a smaller and less obtrusive tip contour, volumetric reduction in tip cartilage inevitably leads to a simultaneous reduction in skeletal support, making excisional techniques unpredictable, haphazard, and prone to delayed deformity. Conversely, by conserving the existing tip cartilage and achieving contour enhancements using cartilage repositioning, suture-based re-contouring, and augmentation grafting techniques, an elegant tip contour can be achieved with far greater long-term stability.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) recognize the pitfalls and limitation of traditional (excisional) rhinoplasty techniques; 2) learn new ways to achieve enhanced tip contour without large-scale cartilage excision; and 3) appreciate the benefits of cartilage conservation to long-term skeletal stability.

IC04 How to Perform an Endoscopic Forehead Lift that Works for the Short and Long Term—It is in the Technique and Surgical Details (Borgne)
Stephen W. Perkins, MD and Heather Waters, MD
Summary: Minimal incision endoscopic forehead lifting approach to brow rejuvenation has been questioned as to its efficacy in the short and long term, especially with comparative respects to “older” full coronal incision techniques. This course will detail the specific techniques and demonstrate that a well performed endoscopic forehead lift procedure is not only successful in the short term but has long lasting results. Intraoperative photos, illustrations, and videos will detail the surgical techniques required, including myotomies and myectomies. Results of one to eighteen years will be shown and statistically validated.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) learn about various proposed ways of forehead brow lifting and identify a specific way of performing an endoscopic FHL. Learn that each endoscopic forehead lift performed by different surgeons varies tremendously; 2) learn that each forehead lift requires myotomies and myectomies to insure short and long term efficacious results, 3) learn a series of specific techniques that produces measurable long term positive results in endoscopic forehead lifting; 4) perform an endoscopic forehead lift or minimal incision forehead lift and produce excellent short and long term results; and 5) realize that there are multiple ways to rejuvenate the brow/forehead complex and have a method to utilize successfully in their practice.

IC05 The Science of Beauty (Maurepas)
Peter A. Adamson, MD
Summary: The search for beauty in all of its forms has been with us throughout time. This instruction course presents an historical background of concepts of beauty from the distant past through to the present. It specifically explores the mathematical and biological concepts of facial beauty that are known today. The importance of beauty as it affects our daily lives is discussed. The relationship of cosmetics, fashion and cosmetic surgery in the search for facial beauty is described. Questions regarding the impact of beauty on mate selection and reproduction, and the future of beauty are raised.

IC06 New Techniques and Modifications in Deep Plane Rhytidectomy: A Combined Experience of Over 25 years
Andrew A. Jacono, MD and Neil A. Gordon, MD (Couteau)
Summary: Deep-plane rhytidectomy has undergone various modifications which has lead to better soft tissue mobilization and the ability to accurately diagnose and treat many complex aging issues. Calling on their combined experience of more than 25 years, Drs. Gordon and Jacono will discuss advanced concepts related to deep plane surgery including extending the deep plane flap into the neck for lateral platysmal suspension, the necessity of maintaining a composite flap, direct buccal fat pad treatment, vertical vector lifting to maximize midface improvement, the ptotic submandibular triangle, hairline management as well as defining methods to individualize the technique according to specific patient characteristics.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) discuss the technique and importance of extending the deep plane into the neck for more durable neck rejuvenation; 2) define how the buccal fat pad contributes to jowling and when and how it should be treated; 3) explain the importance of vertical vector lifting for midface rejuvenation in rhytidectomy; 4) analyze how to define a ptotic submandibular triangle contributes to neck laxity; and 5) define facial characteristics that influence incision placement and hairline management.
IC07 Primary Endonasal Rhinoplasty (Maurepas)
Norman J. Pastorek, MD
Summary: The course includes the following elements: patient selection both psychological and physical; importance of analysis of the nose and paranasal face; profile balance; the value of the endonasal approach; the use of various grafts and sutures; and demonstration of immediate and long term outcomes.
Learning Objectives: At the conclusion of the course, participants should be able to evaluate the nose for hidden underprojecting problems and avoid unexpected loss of projection and differentiate between reliable methods to address the nasal septum as it relates to the deviated nose.

IC08 The Male Face: Different Goals for a Different Aesthetic (Chenier)
Michael Reilly, MD; Patrick J. Byrne, MD; Babak Azizzadeh, MD; and Monica Tadros, MD
Summary: This course will provide exposure to the bio-socio-behavioral aspects of attractiveness and application of this knowledge to surgery for the male face. Social science research will be reviewed to delineate our current understanding of male attractiveness. Anatomical differences between men and women will be reviewed, and surgical techniques to address these differences will be explored.
Learning Objectives: At the conclusion of the course, participants should be able to identify the features that differentiate the attractive male vs female face and evaluate surgical techniques for improving male attractiveness.

IC09 Re-Shaping Our Thinking About the Tip: Static, Dynamic and Vector Modeling Applied (Borgne)
Richard Westreich, MD and Minas Constantinides, MD
Summary: No unifying theory to explain nasal tip dynamics has been accepted widely since Anderson’s Tripod Theory. The DART analysis (Dyer), M-Arch Model (Anderson) and the Cantilever Theory (Westreich) approaches were all attempts to supplement the Tripod Theory. This course will apply various theories of tip dynamics to specific primary and revision cases to analyze the theories’ effectiveness in predicting surgical outcomes. Through this exploration, participants will understand the predominant theories and be able to contrast them to the gold standard of the Tripod Theory. Extensive preoperative analysis and intraoperative photos and video will supplement the discussion. Most importantly, poor outcomes will be explained based upon where theoretical applications went wrong or were incorrectly applied.
Learning Objectives: At the conclusion of the course, participants should be able to recognize the various nasal tip support models to assist with surgical planning and integrate expanded fund of knowledge when assessing poor outcomes after previous surgery.

IC10 Fear and Fascination, Love and Loathing: Addressing Patient’s Attitudes Toward Plastic Surgery, The Key to Success (Couteau)
James C. Marotta, MD
Summary: The course will explore the basis of patient’s attitudes toward plastic surgery from the intrapersonal, social, and cultural perspectives. The reasons plastic surgery is so often the object of fear and loathing and why the concept of cosmetic alteration inspires such passionate objection will be elucidated as it relates to roots in individual identity and perception. Why it seems the cards are stacked against cosmetic surgeons and the fascination the patient’s and the public have with plastic surgery nightmares will be examined. The course will elucidate how addressing patient’s attitudes and fears is the key to success and offer some practical and ethical techniques to put into practice.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) measure financial success of a developing practice; 2) learn strategies for developing relationships with other medical groups; and 3) have a higher level of comfort developing a facial plastic surgery practice in a fluid environment.

IC11 Managing Your Practice in a Changing Environment
Mark M. Beaty, MD and Brooke Loftis, MD (Nottaway)
Summary: This course will address how to manage the business, personal and staffing challenges of a facial plastic surgery practice in the dynamic environment of modern health care. Using the development of my practice as example the course will address the pros and cons of integrating with a larger group and how that relationship may evolve. The course will also address management of uncertainty in a changing economic and healthcare environment. Finally, a discussion of future directions for management and marketing of facial plastic surgery will be addressed.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) explain some of the root causes influencing individual attitudes toward cosmetic surgery and outline techniques to overcome patient’s fear and objections to cosmetic surgery to increase practice success.

IC12 Is There a Role for the Minimally Invasive Facelift?
Paul J. Carniol, MD (moderator); Harry Mittelman, MD; Phillip R. Langsdon, MD; E. Gaylon McCollough, MD; and Fred G. Fedok, MD (Grand E)

IC13 JAMA Facial Plastic Surgery (Oak Alley)
Wayne F. Larrabee, Jr., MD and John S. Rhee, MD

IC14 A Comprehensive and Effective Approach for Midfacial Rejuvenation for the 21st Century: An Evidence-Based Approach (Maurepas)
Edwin F. Williams, III, MD
Summary: A clear understanding of the aging process of the lower eyelid and midface continues to evolve. Over the past 15 years there has been an explosion of options in providers with much less insight toward effective and safe rejuvenation in this area. This course will attempt to highlight our current understanding, options, and limitations for rejuvenation of this area based on a 3 dimension model. The role and details for appropriate surgical intervention will be presented by tailoring the surgical rejuvenation for the patient and this will be carefully discussed.
Learning Objectives: At the conclusion of the course, participants should be able to discuss relevant details of the aging process in the midface and lower eyelid and cite several non-surgical and surgical options for midface and lower eyelid rejuvenation.
The Middle Vault, the Nasal Valve: Form and Function in Rhinoplasty (Gouteau)
Fred G. Fedok MD and Craig S. Murakami, MD
Summary: The surgical management of the middle vault and other nasal valve structures has generated an incredible amount of interest among rhinoplasty surgeons over the last two decades. Because of the demonstrated profound impact on nasal appearance and function, numerous techniques have been recommended to preserve and repair these nasal anatomic structures. Flaps, grafts, suture techniques, and solid and injected implant materials have been advocated. Successful management of the middle vault and the other nasal valve areas has been demonstrated via endonasal as well as open rhinoplasty techniques. In this course the instructors will review the important anatomy of the area. The current evidence based data regarding the relevance of techniques will be presented. The instructors will then discuss case based recommendations of the techniques that they find helpful in management of the middle vault and the external nasal valve. The discussion will feature still and video images to illustrate the principles.
Learning Objectives: At the conclusion of the course, participants should be able to recognize the anatomic structures that make up the commonly described middle vault and nasal valve areas and discuss the common methods to remedy problems in the middle vault and nasal valve areas.

Mindfulness: A Principle of Tremendous Value to Plastic Surgeons (Nottaway)
Jeffrey S. Epstein, MD
Summary: The incorporation of mindfulness and the embracement of some fundamental non-parochial but universal Buddhist principles, has helped to effectively deal with the challenges of ones practice. Incredibly simple, being mindful allows the practitioner to assume a state of understanding and calmness, in all situations. Able to be practiced free from Buddhism, mindfulness is a non-religious approach to life, where the past is just that, the future is an unknown, and all that matters is this very moment. Mindfulness is experienced deepest through meditation, an exercise that can consist of as long as hours at a time, or as brief as a simple pause of several seconds. When incorporated with some basic Buddhist principles (kindness, compassion), mindfulness can be even more effective in dealing with our challenges as plastic surgeons. The central teachings of Buddhism deal with the nature of suffering and dissatisfaction, particularly that related to growing old, and the anxiety of trying to hold onto things that are constantly changing.

How to Get Predictable Results in Rhinoplasty
Dean M. Toriumi, MD (Grand E)
Summary: Rhinoplasty can result in unpredictable outcomes when the nasal structure is weakened through resection of tissues. Use of structural grafts can stabilize the nose and provide consistent aesthetic and functional outcomes. This course will review structural grafts that are used to provide predictable long term outcomes. Variant nasal anatomy predisposing to poor outcomes will be reviewed. Nuances of spreader grafts, caudal septal extension grafts, lateral crural strut grafts, alar rim grafts, and tip grafts will be covered. Methods to improve predictability with the use of costal cartilage and auricular composite grafts will be covered as well.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) become more familiar with the use of structural grafts in rhinoplasty; 2) identify patients that are at higher risk for a poor outcome; 3) execute structural grafting maneuvers with improved reliability; and 4) employ these techniques in their practice and improve their long term rhinoplasty outcomes.

IC18 Forehead Flap Surgery: Lessons learned from the Master and Applications to Everyday Successful Reconstructions (Borgne)
Gary C. Burget, MD and Steven R. Mobley, MD
Summary: Dr. Burget has an internationally renowned reputation in achieving excellent reconstructive results in nasal reconstruction. Dr. Mobley had the opportunity to train under Dr. Burget over 10 years ago during fellowship. Many AAFPRS members will find it interesting to learn what key foundational principles from the Master (Dr. Burget) that are used daily by the “pupil” (Dr. Mobley) to achieve similar high quality reconstructive results. The audience will learn and gain insight into which of Dr. Burget’s principles really form the foundational core for designing and executing successful nasal reconstructions. These foundational principles can be conveyed in a one hour course. Course participants will be able to learn in more depth what these key principles are; and how understanding them allows each individual surgeon to increase the quality of their own reconstructive results.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) analyze nasal defects and the design of the initial donor flap and associated grafts; and 2) review newer published (and not yet published) techniques that can be utilized to improve long term vestibular patency in forehead flap reconstruction.

IC19 Endoscopic Brow Surgery: A Segmental Approach that Improves the Predictability of Post-op Results (Chenier)
Michael Freeman, MD
The instructor will share what he has learned concerning the need to modify ones dissection and lift depending upon the patients pre-operative degree of brow ptosis, strength of the brow depressors and thickness of their skin. Taking these three factors into consideration, patients are divided into three different categories and perform either a lateral brow lift, a 3/4 brow lift or a full brow lift, if they are asymmetric. A different approach on each side is frequently done. State of the art operative videos, and ways to categorize patients and do the different releases will be included.

IC20 VIDEO SESSION: Techniques in Facial Reconstruction, Part I (Maurepas)
Daniel S. Alam, MD
IC21 New Concepts in Middle Vault and Tip Surgery
Kovacevic Milos, MD (Oak Alley)
Summary: This course will offer three major innovations in rhinoplasty: 4 modifications of the spreader flap technique, a new method for correction of the middle vault, and new concepts in tip suture techniques. The instructor will present a new classification for spreader flaps which can be used for widening and narrowing the middle vault. Four specific modifications of the spreader flap are described, including: basic, supporting, flaring and interrupted spreader flaps. Another innovation to be discussed will be the “upper lateral steal technique” which is an effective treatment for the inverted-V deformity. Lastly this course will cover new advances in tip suture techniques. The “cranial tip suture” offers the ability to create an aesthetic tip while maintaining alar rim support. In addition the “L-release technique” prevents postoperative lower lateral cartilage distortion after treatment of LLC convexity.
Learning Objectives: At the conclusion of the course, participants should be able to identify difficult problems encountered in revision rhinoplasty and discuss their potential solutions.

IC22 Integrating Quality Skincare into Your Facial Plastic Surgery Practice (Nottaway)
Lisa Grunebaum, MD and Elizabeth Chance, MD
Summary: This is an updated review of ethical approaches to advising patients on skin care. The following areas will be covered: individualized skin typing and skin regimens, treating pigment, when to use prescription topicals, favorite over the counter ingredients and for sale in-office skin care lines. We will also discuss using skin care in a comprehensive approach to facial beauty including using skin care as a marketing tool.

IC23 Finesse in Revision Rhinoplasty: Pearls and Observations (Couteau)
Andrew Frankel, MD
Summary: The course will begin with general principles of revision rhinoplasty, including anatomic considerations, computer imaging, and surgical planning. Individual revision rhinoplasty cases will be presented, and their specific problems and potential solutions will be identified. Some commonly encountered difficulties that will be reviewed include the over-reduced dorsum, dorsal irregularities, the short nose, excessive columellar show, alar notching, and overprojection. Also discussed will be tip deformities such as the twisted tip and irregularities from prior transdomal sutures or vertical dome division. Complications of revision rhinoplasty, such as skin necrosis, will also be reviewed.
Learning Objectives: At the conclusion of the course, participants should be able to identify difficult problems encountered in revision rhinoplasty and discuss their potential solutions.

IC24 Nasal Surgery on the Geriatric Patient (Borgne)
Stewart C. Little MD; Fred J. Stucker, MD; and Timothy S. Lian, MD
Summary: This didactic course details the aging nose with special emphasis on diagnosis and treatment of the ptotic nasal tip, nasal collapse with valve compromise, and rhinophyma. The basis of the course is a review of nearly 400 patients over 60 years of age who underwent reconstructive and/or cosmetic nasal surgery, including a large series of patients treated for rhinophyma.
Learning Objectives: At the conclusion of the course, participants should be able to recognize the changes in nasal physiology that occur with aging and incorporate the presented techniques to maximize functional and aesthetic outcomes for elderly patients and apply the appropriate steps to surgically address rhinophyma and the ptotic nose.

IC25 Blepharoplasty: Why Transcutaneous Techniques are Still State of the Art (Grand E)
Stephen W. Perkins, MD and Jaspreet Prischmann, MD

IC26 Optimum Mobility Facelift: A Revolutionary Approach using ‘Smart’ Sutures and Minimal Dissection (Chenier)
Nabil Fanous, MD
“Optimum Mobility facelift is a new and radically different approach to rhytidectomy that achieves maximum results with ‘smart’ sutures and minimum dissection. The idea of the “Optimum Mobility” facelift can be explained through the following quiz: A patient comes to see you for a facelift. She places two fingers in front of her ear and gently pulls her skin laterally to show her desired result, producing an impressive improvement on her face and neck. This improvement is achieved with just two fingers placed laterally on the cheeks, without using any incisions, without performing any dissection, without raising any flaps and with only applying a minimal force externally on the skin. Now comes the logical question: How come the result achieved so easily with two fingers is so hard to obtain with the vast array of facelift techniques including the ones using major dissection, composite or deep flaps, mobilization of ligaments, etc.? The answer to this question involves two new concepts: The first one is called the “Intrinsic Optimum Mobility Phenomenon” (it explains the rules that allow the mobilization of facial tissues without dissection). The second concept is called the “Optimum Mobility Points” (if the dissection is carried beyond these points, the surgical result decreases rather than increases). This new approach has the advantages of excellent results, very limited post operative edema and high safety. A live-surgery video will display the consecutive steps of the “Optimum Mobility” facelift.

IC27 Repair of Septal Perforations: Classic Techniques and New Innovations (Oak Alley)
Ivan Wayne, MD and Steven R. Mobley, MD
Summary: This course aims to address one of the most difficult problems facing the rhinoplasty surgeon, repairing septal perforations. This diagnosis is universally frustrating to both the patient and the treating surgeon, often resisting well planned attempts at repair. Two experienced rhinoplasty surgeons will review the key technical aspects to success of
some of the more well known available techniques. Less commonly known techniques and “pearls” will also be discussed. Information on patient selection, pre-operative counseling, post operative management, and typical success rates will be reviewed from the instructors’ experience as well as published studies. Intraoperative photographs and video will supplement the discussion. Audience interaction will be encouraged to add additional educational value to the discussions.

Learning Objectives: At the conclusion of the course, participants should be able to evaluate the specific causes of a septal perforations and formulate a plan of practical techniques to address the problem.

IC28 The Socratic Method (Chenier)
Grant S. Hamilton, MD
Summary: As facial plastic and reconstructive surgeons, we are the stewards of the face. It is imperative that we understand not only the latest technical advances in surgery but also the effect these surgeries have on relationships and quality of life. This instruction course will examine the moral framework underlying patients’ motivation for cosmetic surgery in the context of American social expectations. This session will use the Socratic method as a framework for a dialogue amongst the attendees. A successful instruction course will depend upon attendee participation.

IC29 Handling Extensive Facial Soft Tissue and Skeletal Injuries (Grand E)
Fred G. Fedok, MD; Phillip R. Langsdon, MD; and Krishna Patel, MD
Summary: This course will discuss cases of extensive facial trauma, from fractures to gunshot wounds. Presenters will describe methods to handle extensive fractures; re-establishment of facial buttresses to handling palatal and other complicated unstable cases. The format is based on audience interaction and dialogue between the audience and presenters.

Learning Objectives: At the conclusion of the course, participants should be able to develop a plan to reconstruct the massively fractured patient and employ a new paradigm of understanding to approach total nasal reconstruction of a trauma patient.

IC30 VIDEO SESSION: Techniques in Facial Reconstruction, Part II (Maurepas)
Daniel S. Alam, MD

IC31 Blepharoplasty-Re-Creating the Beautiful Eye (Borgne)
Jill Hessler, MD and Gregory Branham, MD
Summary: Eyelid anatomy as it pertains to and effects blepharoplasty surgery will be reviewed. The effects of adjunctive procedures pre-operatively such as filler injections and timing of surgery will be reviewed. Surgical techniques and equipment such as transconjunctival blepharoplasty and skin muscle flap will be reviewed. Adjunctive treatments including fat transfer, laser resurfacing and chemical peels will be reviewed and demonstrated in video.

Learning Objectives: At the conclusion of the course, participants should be able to draw the eyelid anatomy and show how to avoid complications in each lamella and identify three adjunctive treatments to the eye area used to enhance specific ocular concerns.

IC32 Nasal Augmentation in Ethnic Rhinoplasty Using Custom-Carved Silicone Implants (Couteau)
Oleh Slupchynskyj, MD
Summary: This course is designed to offer a new way to augment the ethnic nose using custom-carved silicone implants. In addition, participants will learn techniques for reducing infection and movement.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) carve custom silicone implant; 2) insert and secure custom carved implant through open approach; 3) know pearls on avoiding infection and movement of the implant after insertion.

IC33 ‘Mini-Incision’ Rhinoplasty: A New ‘Paradigm Shift’ Approach Using Tiny Incisions and Minimal Dissection (Nottaway)
Nabil Fanous, MD
Traditionally, two rhinoplasty approaches have been described: the ‘open’ and the ‘closed’. The third approach introduced here, the “Mini-Incision” rhinoplasty, is a new technique using both minimal incisions and minimal dissection to produce the same esthetic changes achieved by the traditional open and closed techniques. The advantages are high preservation of the structural nasal supports, reduced post-operative edema, shorter operating time and more predictable results. The main disadvantage, like any new minimally-invasive technique in other surgical specialties, is the learning curve. However, once its basic rules are understood, the “Mini-Incision” rhinoplasty becomes easy to perform and highly predictable. A ‘live surgery’ video presentation will display the consecutive steps for the ‘Mini-Incision’ rhinoplasty.

IC34 Nasal Valve Repair: A Structurally Integrated Approach (Maurepas)
J. Madison Clark, MD and Ted A. Cook, MD
Summary: The original publication of the Butterfly graft technique, and results in the first cohort of functional secondary rhinoplasty patients was published in 2002. Since the original description, the course director(s) have extended the indications for this technique to primary rhinoplasty patients. With over 10 years experience with over 500 patients, the technique has become an invaluable adjunct to the approach of both primary and secondary nasal valve repair. The evolution of this technique has yielded practical pearls that allow the Butterfly graft to be used in conjunction with some of the more traditional nasal valve techniques, as well as other techniques that have been developed since the original description. The attendee will receive a step-by-step description of open and closed approaches to these rhinoplasty maneuvers.

Learning Objectives: At the conclusion of the course, participants should be able to understand the rationale behind the appropriate choice for nasal valve repair among the various options, including the Butterfly graft, spreader graft, flaring suture, upper lateral cartilage turn-in, and other commonly utilized nasal valve reconstruction techniques.
IC35 Rhinoplasty in Wegener’s Granulomatosis: An Update
On Workup, Treatment and Surgical Care
Andrew Winkler, MD and Adam Terella, MD (Maurepas)

Summary: Wegener’s Granulomatosis causes profound disfigurement of the nose. The disease is lifelong and it is often difficult to decide when surgery may be safely undertaken. New blood tests (MPO, PR-3) are now available that help to determine if a patient is in remission. This course discusses today’s standard of care for the work-up of Wegener’s Granulomatosis as well as the role of nasal septal biopsy. We also discuss at length our recommendations for safe and reliable rhinoplasty techniques that will correct the typical deformities of this disease.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) order the correct labs to diagnose Wegener’s Granulomatosis and determine if a patient is in remission; 2) formulate an appropriate plan for rhinoplasty in patients with Wegener’s Granulomatosis; and 3) discuss the techniques used in his practice that deliver consistent high level results for nasal obstruction while maintaining good aesthetic outcomes.

IC36 Advanced Dynamic Grafting in Functional Rhinoplasty (Grand E)
Benjamin C. Marcus, MD

Summary: Internal nasal valve (INV) narrowing is a major cause of nasal obstruction. Dysfunction of the valve can be either static or dynamic. The majority of current techniques emphasize a static repair of the valve. The butterfly graft remains the most effective tool for repair of dynamic INV collapse. The speaker will review advanced dynamic grafting techniques used in his practice that deliver consistent high level results for nasal obstruction while maintaining good aesthetic outcomes.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) identify patient who require a dynamic rather than just static repair of the INV; 2) create a surgical plan that addresses specific dynamic repair of the INV; and 3) utilize advanced grafting techniques that make this graft usable in any nose.

IC37 Acne Rosacea: The Red Face (Chenier)
David A.F. Ellis, MD

Summary: Definition, classification, pathophysiology, and various treatments will be reviewed. The use of non-ablative vascular laser will be discussed with the science and understanding of laser-skin interaction so that a full understanding of how these lasers are effective in treating the red face. A discussion of the treatment of rhinophyma with video will be included so that a full understanding of treatment and the avoidance of complications will be discussed.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) apply classification of the participant will to select the best set of; 2) differentiate among topical medication, oral medication, and various laser treatments can wisely be selected to decrease the red face; and 3) discuss fully the pathophysiology of Rosacea.

IC38 Prevention and Management of DVT and PE Within An Office Based Surgical Facility (Nottaway)
J. Kevin Duplechain, MD

Summary: This course will review the basics of DVT prevention and keys to early management. Risks factors such as; Factor V leiden, protein S and protein C deficiency and evaluation will be reviewed. Specific risks in the operating room such as positioning, use of compression devices, and general versus sedation cases will be discussed. Early recognition and evaluation with D dimer testing along with traditional evaluations will be reviewed. The course is designed to heighten the awareness and review basic protocols to ensure safe outcomes for patients.

Learning Objectives: At the conclusion of the course, participants should be able to develop a risk protocol for DVT prevention in office surgery setting including indications for further test prior to surgery and the use of LMWH and recognize early DVT and PE with management protocols.

IC39 Management of Hemangiomas and other Vascular Anomalies (Borgne)
Marcelo Hochman, MD

Summary: Management of vascular anomalies (hemangiomas and malformations) has evolved from the “leave it alone, it will go away” dogma to a sophisticated multi-modality therapy with reproducible results. The facial plastic surgeon has an opportunity to play a central role in the management of the 400,000 children who are born in the USA every year with a vascular anomaly. This course will review the pathophysiology, natural history and medical/laser and surgical therapeutic options. Clinically applicable information will be presented.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) define vascular anomalies and the differences between the tumors and malformations; 2) describe the available medical, laser and surgical modalities of treatment for hemangiomas; and 3) translate the management of vascular anomalies (hemangiomas in particular) into clinical practice.

IC40 Pricing Strategy for Facial Plastic Surgery Practices
Karen Zupko (Couteau)

Summary: Before you put your services on sale, make deals or engage in discounting – attend this session. You will learn about pricing strategies from a marketing perspective. Why matching the so-called competition may tarnish your brand. Learn what consumer research has to say about pricing strategies from a marketing perspective. Why matching the so-called competition may tarnish your brand. Learn what consumer research has to say about relationship and discount buyers. Having staff that can educate patients on your value is critical. Leave with tips on how to assess the value effort in your office.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) evaluate your fee schedule using surveys and common sense; 2) know pricing strategy and tactics suitable for facial plastic surgery and medspa services; 3) learn that forms of discounting are effective; 4) perform consumer research about buyers’ behavior; 5) assess how fees are presented on your quote; and 5) determine if you staff is effective in dealing with pricing objections.
INSTRUCTION COURSES 41-46

IC41 Advanced Surgical Approaches to Vascular Malformations and Hemangiomas to the Face and Neck in Infants and Children (Maurepas)
Edwin F. Williams, III, MD
Summary: Significant vascular malformations and hemangiomas continue to challenge facial plastic and reconstructive surgeons as well as managing physicians despite progress in medical intervention. A systematic approach to managing difficult vascular malformations and hemangiomas to the face and neck will be presented on natural history, functional deficits, psychological aspects as well as 20 years of surgical management of advanced head and neck tumors. Learning Objectives: At the conclusion of the course, participants should be able to: 1) differentiate clearly the difference between hemangiomas and vascular malformation based on history and physical exam; 2) discuss the appropriate algorithm for surgical intervention; and 3) discuss technical aspects important and relevant to the surgical intervention of vascular malformations and hemangiomas.

IC42 Optimal Application of Computer Imaging for the Rhinoplasty Patient (Goutreau)
Behrooz A. Torkian, MD and Andrew S. Frankel, MD
Summary: The course will cover the use of traditional and three-dimensional imaging in the analysis, planning, conversion, and execution of rhinoplasty. The presentation will discuss how imaging may be used in diagnostic analysis and correction of specific nasal deformities. Emphasis will be placed on practical use of commercially available software to aid in the efficiency of communication between the physician and prospective rhinoplasty patient during consultation. Techniques will be presented for the establishment of realistic goals, surgical objectives, and transition to surgical execution. This technology increases precision and effectiveness of preoperative planning, as well as the transition between planning and execution of successful surgery. Learning Objectives: At the conclusion of the course, participants should be able to: 1) discuss difference between 2-dimensional and 3 dimensional imaging; 2) recognize the strengths and limitations of imaging; and 3) apply one or both types of imaging to improve, results, patient satisfaction, and conversions in a rhinoplasty practice.

IC43 Systematic Reviews for Facial Plastic Surgeons: Pearls and Pitfalls (Oak Alley)
Lisa Ishii, MD and Travis Tollefson, MD
Summary: Systematic reviews are valuable literature reviews that attempt to sum up the best available research on a specific question. Because of their ability to pool results from multiple studies they are becoming increasingly important for establishing “best practice” guidelines. In this course we will provide members with a step by step overview of the systematic review process. At the end of the course members will have a “toolkit” for interpreting a review or preparing a systematic review on their own. They will be able to critically appraise a review for its quality, and for its usefulness to their practice. Learning Objectives: At the conclusion of the course, participants should be able to critically evaluate and prepare a systematic review.

IC44 The Shrink Wrap Facelift: Combining Laser Resurfacing with Fat Grafting and Facelift Surgery (Nottaway)
J. Kevin Duplechain, MD
Summary: This course will share the speaker’s experience with over 500 facelift cases combined with fat grafting and laser resurfacing. The case presentations will provide insight into planning a browlift, facelift, blepharoplasty, and necklift with combined fat grafting and laser resurfacing to include all aspects of the face including eyelids and neck. Specific nuances regarding blepharoplasty and neck treatment are reviewed taking into account the effect of the laser. Since aging involves effects of gravity, volume loss, and aging of the skin, the most comprehensive treatment should involve treatment of all three causes. Fully ablative CO2 procedures are utilized throughout. Avoiding complications will be addressed as well. Learning Objectives: At the conclusion of the course, participants should be able to: 1) immediately perform combined facelift, fat grafting and laser resurfacing resulting in better outcomes than facelift surgery alone; and 2) safely perform these procedures with specific parameters being made available regarding laser safety, post laser care, and volumes of fat typically utilized, minimizing potential untoward events.

IC45 Finesse with Fillers and Neurotoxins (Grand E)
Theda C. Kontis, MD
Summary: This course will present advanced injection techniques for the physician who performs only basic injections of fillers and neurotoxins. Going way beyond the basics of neurotoxins for the brow and filler for the nasolabial folds, the participant will learn how to sculpt the face with injectables. The.key to using these treatments is understanding the underlying anatomy, which will be detailed precisely in this course. Management of complications of fillers and neurotoxins will be outlined. Learning Objectives: At the conclusion of the course, participants should be able to: 1) refine their skills as a cosmetic injector for fillers and neurotoxins; 2) have a treatment plan should complications occur; and 3) appraise the changes of the face with aging and determine how fillers and neurotoxins can be used to sculpt the face.

IC46 Newer Approaches and Techniques to Improve Efficiency in Facial Trauma Surgery (Chenier)
Amar Suryadevara, MD
Summary: In this course we will discuss surgical techniques which save time and yield similar outcomes in repair of facial fractures. We will discuss ways to improve efficiency of the coronal approach. We will discuss various orbital approaches including the precaruncular and lateral retrocanthal approach which provide wide orbital exposure. A closed suture technique for reduction of zygomatic arch fractures will be discussed. In addition we will discuss mandibulomaxillary fixation with a 22 gauge emasbrasure wire as opposed to standard arch bar placement or use of mmf screws. Learning Objectives: At the conclusion of the course, participants should be able to describe newer approaches to the facial skeleton and newer techniques for repair of facial fractures which improve efficiency of these surgical procedures.
IC47 Improving Results In Facial Scar Treatment (Borgne)
J. Regan Thomas, MD and David B. Hom, MD
Summary: A sophisticated approach to treatment of linear facial scars will be presented. Emphasis will be placed on initial scar analysis and selection of appropriate treatment alternative procedures. A stepwise description of surgical techniques will be presented and a selection of post operative photographs will be exhibited and used to establish expected post operative results.
Learning Objectives: At the conclusion of the course, participants should be able to analyze a variety of facial scars and select most appropriate techniques for optimum results and utilize a variety of scar revision procedures based on scar type, position, and size.

IC48 How to Make a Beautiful Nose Functional (Oak Alley)
Norbert Gorski, MD
Summary: Nose is responsible for the perceptions of our face. Its beauty is an indicator of face harmony. Its function however is responsible for the comfort of our live. The nose should not attract the attention of the observer - the harmony of the facial features should be natural, it should also gain attention to its owner - its function should be unnoticeable. Knowledge how during the surgical procedure combine the expectations of the holder of the nose to make it beautiful and maintain harmony of the face as well how to make its function unnoticeable to the owner will be the focus of this course.
Learning Objectives: At the conclusion of the course, participants should be able to plan and execute rhinoplasty which will provide satisfactory esthetic result as well as the physiological nasal function and plan and execute rhinoplasty which will provide satisfactory esthetic result as well as the physiological nasal function.

IC49 Alloplastics in Rhinoplasty: hat’s New and What’s Safe (Borgne)
Andrew Winkler, MD
Summary: This course evaluates the advantages vs. incidence of complications from high-density polyethylene (Medpor), expanded polytetrafluoroethylene (GoreTex), vulcanized silicone and Polydioxanone plate (PDS Flexible Plate). A retrospective review of over 1000 rhinoplasty procedures was used to gather objective data for this discussion. The incidence and types of complications will be discussed, as well as ways to treat and avoid them. In addition, the benefits of certain alloplastic materials will be discussed.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) describe the benefits and limitations of Medpor, GoreTex, Silicone and PDS Flexible Plate in rhinoplasty; 2) describe the indications for certain alloplastic materials; and 3) analyze the use of alloplastic materials with greater objective knowledge base.

IC50 Current Trends and Contemporary Refinements in Facial Fillers (Maurepas)
Babak Azizzadeh, MD, Guy G. Massry, MD, and Donald B. Yoo, MD
Summary: The rapidly growing landscape of nonsurgical facial rejuvenation with dermal fillers is discussed, with specific emphasis on indications, technical pearls, safety and results based on our own collective experience and a review of the literature. The characteristics, strengths and disadvantages of each commercially available filler will be highlighted. The various injection techniques will be reviewed, with focus on the blunt cannula technique and its varied applications throughout the face.
Learning Objectives: At the conclusion of the course, participants should be able to describe the characteristics, and appropriate indications for each of the commercially available facial fillers and choose from safe and effective injections of facial filler to each anatomic location.

IC51 Straightening the Crooked Nose (Chenier)
Ivan Wayne, MD and Douglas M. Sidle, MD
Summary: This course aims to address one of the most difficult problems facing the rhinoplasty surgeon: the crooked nose. Two experienced rhinoplasty surgeons review the most complicated cases of crooked noses in their practices. A systematic approach to nasal-facial analysis will be stressed followed a review of the various options for treating the bony dorsum, the cartilaginous middle vault, the tip and nasal base deviations. An emphasis will be placed on optimizing nasal function while improving cosmesis. Both instructors will critically review each case with regard to technique and outcomes. Intraoperative photographs and video will supplement the discussion. Audience interaction will be a key component of the discussion.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) critically evaluate the specific causes of a crooked nose; 2) formulate a plan of practical techniques to address the problem; and 3) integrate at least two new techniques in rhinoplasty immediately into their own practice.

IC52 Surgery For Migraines: An Opportunity for the Facial Plastic Surgeon (Nottaway)
Marcelo Hochman, MD
Summary: Migraines affect 25% of the female population in the 25-55 years of age group; accounts for over $13 billion in lost productivity and over $1 billion in direct medical costs. Variations on several surgical procedures which are commonplace in facial plastic surgery have been found to significantly improve the incidence and severity of migraine headaches. This course will cover the basics of migraine headache physiology, the specific surgical procedures to deactivate the trigger zones for migraines and the supporting literature.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) define migraine headaches, their pathophysiology and the theory of migraine trigger zones; 2) describe the procedures used to deactivate the trigger zones for migraines; and 3) formulate a plan to incorporate migraine surgery into their practice.

IC53 Salvage Rhinoplasty Surgery for the Severely Deformed Nose (Grand E)
Russell W.H. Kridel, MD
Summary: Minor revision rhinoplasties provide little difficulty, but major revisions are incredible challenges to even the most skillful rhinoplasty surgeon, often requiring significant corrections of scarring, previous over-resection, asymmetries,
and irregularities often worsened by vagaries of healing. The surgeon often must first recreate with grafts the normal anatomy before even attempting an aesthetic improvement. At times the aesthetic result from the first surgery also is complicated by new airway problems that must be addressed. Learning Objectives: At the conclusion of the course, participants should be able to: 1) recognize what causes major problems in rhinoplasty so as to avoid them; and 2) become familiar with grafting options and harvesting skills in revision rhinoplasty.

IC54 Nasal Base Surgery: Indications, Techniques, Complications, Secrets (Couteau)
Alireza Mesbah, MD
Summary: The following will be covered in this course: indications of nasal base surgery such as alar base reduction; the most common complications after this procedure; and some secrets on how complications can be prevented to achieve great results. The speaker will show different video clips on various techniques of nasal base surgery. Learning Objectives: At the conclusion of the course, participants should be able to examine rhinoplasty patients for the necessity of nasal base surgery and analyze various nasal base surgery techniques to determine the best fit for optimal outcome.

IC55 Management Strategies for Nasal Valve Obstruction
Stephen Goldstein, MD and Oren Freidman, MD (Borgne)
Summary: A facial plastic surgeon has to fully assess the possible causes of nasal obstruction. They must fully understand the function and normal anatomic relationships of the osteocartilaginous nasal skeleton. Surgical management of nasal valve obstruction must account for any disruption involving the nasal bones, midvault, nasal tip, and underlying septum. No two noses are truly the same; a reality that increases the complexity of this problem. Optimal treatment to restore a functional airway and improve cosmesis requires addressing all of the anatomic issues. This course will review strategies to diagnose and treat these issues. Learning Objectives: At the conclusion of the course, participants should be able to: 1) identify the different causes of nasal valve obstruction; 2) differentiate between internal and external nasal valve obstructions; and 3) to implement surgical and non-surgical management strategies to treat nasal valve obstruction.

IC56 Coding and Documentation for the Facial Plastic and Reconstructive Surgeon (Oak Alley)
P. Daniel Ward, MD and Krishna Patel, MD
Summary: Coding and documentation are two of the most important aspects of medical practice, yet are often overlooked in residency and fellowship training. This course intends to provide an overview of coding for common procedures performed in facial plastic surgery, such as facial defect reconstruction, functional rhinoplasty, facial reanimation, and facial trauma. In addition, documentation tips to help improve patient care, ease future research efforts, minimize malpractice risk, and improve insurance pre-authorization and payment will be provided. The main audience target is surgeons who have been in practice for less than five years, fellows, and residents, but even the seasoned facial plastic surgeon may find the information to be of benefit. Learning Objectives: At the conclusion of the course, participants should be able to: 1) demonstrate an ability to correctly code for commonly performed facial plastic and reconstructive procedures; and 2) demonstrate an increased knowledge of documentation practices that will help improve patient care, ease future research efforts, minimize malpractice risk, and improve insurance pre-authorization and payment.

IC57 Management of Septal Perforations (Couteau)
Stephen F. Bansberg, MD and Andrew Courson, MD
Summary: Interest in septal perforation repair has increased. Procedures proposed to close perforations will be reviewed. A surgical technique using bilateral mucosal flaps, placement of an interposition graft, and application of protective silastic sheeting will be presented in detail Perforation and septal characteristics affecting outcomes will be addressed. Case presentations will highlight the decision process used in managing these challenging lesions. This course will describe the construction of custom prostheses using CT and three dimensional modeling for perforations in which attempted closure is not feasible. Learning Objectives: At the conclusion of the course, participants should be able to evaluate the feasibility of attempting closure of a septal perforation and apply a surgical technique for perforation closure utilizing bilateral mucosal flaps, an interposition graft, and protective silastic sheeting.

IC58 Muscle Tendon Unit Transfer for Facial Reanimation
Kofi D. Boahene, MD and Linda N. Lee, MD (Chenier)
Summary: Muscle tendon unit (MTU) transfer offers the potential for restoring facial tone, symmetry, and motion to the paralyzed face in a single-stage procedure. The principles of MTU transfer established for hand surgery can be adopted to optimize dynamic excursion of the temporalis tendon transfer procedure for facial reanimation. The force generating ability of a transferred MTU depends on the ideal length-tension relationship of the donor muscle. This course will review biomechanics and principles of MTU, and explain the specific clinical intraoperative application for the temporalis tendon transfer procedure that will optimize excursion. Other important factors including patient selection, timing and indication of the MTU, and role of physiotherapy will be discussed. Learning Objectives: At the conclusion of the course, participants should be able to: 1) advance and refine the technique and outcome of temporalis muscle tendon unit transfer by understanding proper selection of the donor muscle, patient selection, and length-tension relationship of the donor muscle; and 2) apply biomechanics and principles of muscle tendon unit transfer in facial reanimation to optimize excursion of the transferred tendon.
IC59 Seven Critical Steps - The Crooked Nose Algorithm
Benjamin C. Marcus, MD and Travis Tollefson, MD (Maurepas)
Summary: The crooked nose is a fundamental component of our profession. We will present a systematic approach to this clinical challenge. The course will review each of the critical steps to achieve optimal results. In addition to our own clinical algorithm we will supply review of the key cohort studies that support these techniques. The course will cover: critical injury analysis; pre and post injury management; advanced septrhinoplasty techniques; osteotomies; grafting and camouflage techniques; and repair of the traumatic nasal valve injury.
Learning Objectives: At the conclusion of the course, participants should be able to develop a critical and analytical method to properly diagnose nasal injuries and develop a step-wise algorithm for treatment of the crooked nose.

IC60 Comprehensive Perioral Rejuvenation: Augmentation, Resurfacing and Neurotoxins-What are the Options?
John Bittner, MD; Steven Mobley, MD and Jaspreet Prischmann, MD (Grand E)
Summary: This course will address the many options available for treatment of the senescent lips. This includes description of techniques, evidence in support of an approach and before-and-after photos. Approaches include permanent (Permalip), semi-permanent (SMAS and fat grafting) and non-permanent (dermal filler) lip augmentation, chemical peel, laser and dermabrasion and neurotoxins. A comprehensive approach is often necessary to treat this difficult but important area during facial rejuvenation.
Learning Objectives: At the conclusion of the course, participants should be able to: describe the treatment of the senescent lips often requiring multiple modalities and recognize the importance of addressing the aging perioral area during facial rejuvenation.

IC61 Social Media Boot Camp for Facial Plastic Surgeons
Wendy Lewis and Denise Mann (Nottaway)
Learn from two veteran experts in online media. This course will include: six platforms you need to be on and why; emerging social media channels; best days and times to post and tweet; build a better blog; making sense of social rules for doctors; online habits of cosmetic patients; what makes shareable content; and 10 pitfalls to avoid in the social space. Wendy Lewis is president of Wendy Lewis & Co Ltd, Global Aesthetics Consultancy since 1997, founder/editor in chief of Beautyinthebag.com since 2008, and the author of 11 books, including two editions of America’s Cosmetic Doctors (Castle Connolly Medical). Her company, WLCO Social, specializes in social media programs and strategy in the health and beauty category. Denise Mann is an award-winning health and beauty journalist and the editor of Plastic Surgery Practice. Her articles regularly appear in WebMD, Health.com, Healthday, American Profile and Wall Street Journal. She is also the editorial director for Consumer Guide to Plastic Surgery and All About Facial Rejuvenation.

IC62 Otoplasty: A Simple Technique for the Protruding Ear
Sunny Park, MD and Fred J. Stucker, MD (Maurepas)
Summary: This course concentrates on creating the normalcy of the human ear by focusing on the diagnosis of the defect, surgical technique and postoperative results. The otoplasty technique used by the senior author on over 300 patients will be presented. Specific surgical techniques will be the crux of this presentation with preoperative, operative and postoperative photographs collected over the course of 40 years of experience. In addition, complications are discussed with examples to illustrate prevention. This course will enable facial plastic surgeons and otolaryngologists to reconstruct the common malpositioned auricle.
Learning Objectives: At the conclusion of the course, participants should be able to describe the otoplasty technique which combines lateral conchal bowl resection with mattress suture technique.

IC63 When Less is More and More is Less in Mohs Reconstruction (Grand E)
Tri Nguyen, MD
Summary: Tissue preservation while optimizing cure rates and margin control is the essence of Mohs surgery. This concept is applicable to head and neck reconstructive surgery of oncologic wounds. This course will highlight approaches to Mohs defects that will minimize tissue excision during repairs. Techniques to reduce standing cones, facilitate skin graft harvests, and minimize undermining while still preserving functional and aesthetic outcomes will be discussed. The session will also illustrate flaps with maximal mobility and minimal morbidity as well as flap and graft combinations in the repair of Mohs defects.

IC64 Nerve Grafting and Nerve Transfer Techniques for Dynamic Facial Reanimation (Oak Alley)
Kofi Boahene, MD
Summary: Nerve grafting and transfer techniques are central to restoring movement to the paralyzed face. This course will present techniques for directly repairing interrupted facial nerves and the transfer of hypoglossal, masseter and crossfacial nerves for facial reanimation. Concepts in signal upgrading with end to side nerve anastomosis for partial paralysis is covered. Techniques will be described in a step by step manner and augmented with video recordings.
Learning Objectives: At the conclusion of the course, participants should be able to design a nerve grafting procedure all situations of facial paralysis and identify and mobilize the masseter nerve, hypoglossal nerve and buccal branch of the facial nerve for reanimation.

IC65 Structural Grafting of the Lower Third of the Nose;
Fred G. Fedok, MD (Borgne)
Summary: The shape and structure of the cartilage framework of the lower third of the nose is central to the aesthetic and functional features of the nose. In this course the favorable anatomy of this region of the nose is reviewed, acquired and iatrogenic deficiencies are identified, and surgical remedies are described. Primary and revision cases are analyzed with photographic and video illustration.
Learning Objectives: At the conclusion of the course, participants should be able to demonstrate an improved understanding of the surgery of the lower third of the nose and describe deficiencies and proposed corrections.

IC66 Facial Plastic Surgery Emergencies: Recognition, Management and Prevention of Complications (Chenier)
Sydney C. Butts, MD; Theda C. Kontis, MD; Laura Hetzler, MD; and Krishna Patel, MD, PhD
Summary: The reconstructive cases that require urgent management by the facial plastic surgeon are challenging for a multitude of reasons. There is a need to ensure that residents understand the signs and symptoms associated with these emergencies and acquire the skills in procedures utilized in the management of these cases. Cases presented will include penetrating cheek injury with facial nerve and parotid duct laceration; scalp avulsion, auricular avulsion; retrobulbar hematoma compounding orbital fracture repair or blepharoplasty; orbital floor trapdoor fracture with oculocardiac reflex; bradycardia and syncope; soft tissue complications of injectables and septal hematoma. The faculty will specifically review techniques that should be in the treating physician’s armamentarium for each case. Our target audience is all facial plastic surgeons who may be called upon to treat these cases. We expect it would be particularly beneficial for residents and fellows to reinforce training principles. Evidence-based treatment approaches will be emphasized.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) recognize several specific emergent disease processes that require reconstructive intervention; and 2) identify the bedside and operative procedures that are utilized in facial plastics emergencies, including lateral canthotomy; forced duction testing; microscopic nerve and parotid duct repair.

IC67 Precision in Rhinoplasty (Couteau)
Roxana Cobo, MD and Gilbert Nolst Trenite, MD
Summary: Management of the crooked nose is a challenge for any rhinoplasty surgeon. A careful evaluation and analysis of the nasal bones, cartilaginous vault and nasal septum will be presented. Treatment options will be presented and discussion of new innovative techniques will be shown. Clinical cases will be presented for discussion and videos will be used to show different surgical techniques. The goal of surgery is to obtain a good cosmetic result with a functional nose.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) evaluate and diagnose in a proper fashion a patient presenting with a crooked nose; 2) organize a stepwise approach to the patient with a crooked nose; and 3) evaluate the different surgical options that are available.

IC68 Profile Alignment (Nottaway)
Fazil Apaydin, MD
Summary: The session will involve analysis ‘how we do it’ and surgical planning for lateral profile change and then a description with case examples including video of profileplasty. This will include presentation of dorsal reduction techniques and grafting for contour augmentation and structural support.

IC69 Laser Assisted Facial Contouring (Maurepas)
David Holcomb, MD
Summary: After thorough evaluation of Laser Assisted Facial Contouring (LAFC) using a thermally confined Nd-YAG lipolysis laser, the technique has been extended to the neck (Laser Assisted Neck Contouring or LANC) and to surgical patients, ultimately becoming integral to the presenter’s face and neck lift technique. The technique begins with laser treatment of accumulated fatty tissue of lower face and neck followed by removal via hand syringe liposuction. Implications include potential for improved contour of face and neck, reduced incidence of platysma imbrication and facilitation of flap elevation (fiber laser dissection). Laser lipolysis tissue interaction, related safety issues and avoidance and management of complications will be covered.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) understand laser lipolysis tissue interaction and safe application to structures of the face and neck; and 2) understand the benefits of integrating Laser Assisted Facial Contouring and Laser Assisted Neck Contouring into minimally invasive and surgical management of the aging face and neck.

IC70 Personal Tips for Successful Management of Difficult Noses (Grand E)
Yong-Ju Jang, MD
Summary: In my rhinoplasty practice, difficult noses include short nose, severely deviated nose, and revision cases presenting with severe structural deficit. To properly correct short nose, after lengthening the central segment, I frequently use cartilage flap technique modified from dome division technique. In management of severely deviated nose, I found my modified extracorporeal septoplasty very useful. In severely demolished revision cases, the use of costal cartilage is essential component for success, but it requires special skill and caution. In this lecture, technical detail of cartilage flap technique, modified extracorporeal septoplasty, and proper way of costal cartilage use will be presented. In addition, personal tips on dorsal augmentation and tip plasty in these difficult noses will also be introduced.

Learning Objectives: At the conclusion of the course, participants should be able to: 1) understand technical detail of cartilage flap technique, modified extracorporeal septoplasty, and smart use of costal cartilage for successful correction of difficult noses such as short nose, severely deviated nose, and revision nose with severe structural deficit; and 2) understand tips on dorsal augmentation and tip work.
IC71 Surgery of the Nasal Valves: Optimizing Outcomes for Nasal Obstruction (Chenier)
Amar Suryadevara, MD and Parul Goyal, MD
Summary: The authors will review nasal anatomy, paying attention to the external nasal valve, internal nasal valve, mid-valve region, septal body and inferior turbinates. Abnormalities, anatomic variations, and dynamic changes in the nasal valves will be discussed. The authors will briefly discuss medical treatments as they relate to the various causes of nasal obstruction. The majority of the course will then be spent on surgical treatments for a variety of nasal valvular problems leading to nasal obstruction. The evolution of the endoscope and surgical equipment has resulted in advances in septal surgery and turbinate surgery, which will be discussed. In addition, the authors will discuss nasal valve procedures from a rhinologic and facial plastic perspective.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) describe the nasal anatomy including the external nasal valve, internal nasal valve, and mid-valve regions; and 2) re-state the various treatments for nasal airway obstruction, focusing on surgical management of the nasal valves from a combined rhinologic and facial plastic perspective.

IC72 Concepts, Analysis and Techniques in African American Rhinoplasty (Oak Alley)
Kofi Boahene, MD and Ife Sofola, MD
Summary: Rhinoplasty in patients of African descent in on the rise. An ethnic sensitive approach in analyzing and performing African American rhinoplasty is needed. This course provides concepts in ethnic sensitive rhinoplasty developed from the analysis of the African nose based on observations made in 300 consecutive patients seeking primary and revision rhinoplasty. Techniques for achieving natural looking rhinoplasty results in patients of African decent is presented.
Learning Objectives: At the conclusion of the course, participants should be able to systematically analyze the African nose in an ethnic sensitive manner for aesthetic rhinoplasty and manage the thick skin nose, reduce flared and wide nostrils with minimal scars, create tip and dorsal definition in an ethnically sensitive manner.

IC73 Medical Statistics for the Facial Plastic Surgeon: What You Need to Know (Notaway)
Craig Czyz and Jamie Jenkins, PhD
Summary: Published reports estimate 30% to 90% of peer reviewed medical literature contains statistical errors. The majority of clinical physicians have only a basic knowledge of medical statistics which can lead to errors when reporting data and critically reviewing manuscripts. This raises the concern that clinical practice guidelines and surgical procedures based on these articles may be flawed, jeopardizing patient care. This course will provide an overview of the common methodology and statistical errors encountered in the peer reviewed facial plastic surgery literature. The instructors will provide easy to follow study design and statistics templates for common studies preformed in facial plastics clinical research.
Learning Objectives: At the conclusion of the course, participants should be able outline basic statistical terminology and methods pertinent to clinical research synthesize easy to follow study design and statistics templates for common studies preformed in facial plastics clinical research.

IC74 Raving Patients! A System of Practical, Research-Based Techniques for Improving Healthcare Provider-Patient Communication and Outcomes (Borgne)
Brent Koch, MD
Save yourself from lawsuits, pack your clinic with patients referred by other patients, convert every consultation to a scheduled procedure and love what you do for a living! The handout you receive alone will be worth your attendance to this course. Healthcare is evolving and doctors have to evolve or get left behind. This course will teach you research proven methods and techniques you can use tomorrow to sell patients on their own well-being. Neuro-Linguistic Programming, the Franklin Effect, the Pratfall Effect, Body Language Techniques, Word Anchoring, Diffusing Frustration, Office Feng Shui and many more means for more effectively convincing patients of how you can help them are covered in this course. Presented by a fellow facial plastic surgeon and author of the book by the same name, this is a high energy, entertaining and fully educational course on making you a more successful facial plastic surgeon and simply a more interesting person to talk to. This is a course offered by a doctor passionate about making doctors better doctors.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) reduce malpractice exposure; 2) increase referrals; 3) convert more consultations to scheduled procedures; and 4) gain a renewed appreciation for the gift of the ability to help patients feel better about themselves.

IC75 Microvascular Surgery for the Facial Plastic Surgeon (Maurepas)
Daniel P. Knott, MD and Rahul Seth, MD
Summary: In the current era, microvascular facial plastic surgery is much more than simply filling “holes” in the face and neck. Optimal outcomes depend on control of volume replacement, support of soft tissue structures, color matching, bone reconstruction and central facial subunit reconstruction. This course will identify the technical advancements leading to limiting morbidity, improving form and function, and restoring “normalcy” to our patients. Furthermore, insets may be performed in minimally invasive ways, with minimal access to vascular anastomosis. No longer are free flaps only performed when essential; instead they should be performed when patient outcomes may be improved with limited morbidity.
Learning Objectives: At the conclusion of the course, participants should be able to: 1) identify the different soft tissue microvascular free flaps, the advantages and disadvantages of each and the ideal ways of harvesting; 2) understand the role of osseous flaps in facial reconstruction; and 3) understand the harvesting techniques that permit minimally invasive insetting.

IC76 The Endoscopic Subperiosteal Midface Lift: Pearls, Pitfalls, Step by Step Technique (Maurepas)
Anurag Agarwal, MD and Richard Maloney, MD
Summary: The endoscopic subperiosteal midface lift is a technically challenging procedure, addressing an area of the face that is often neglected in aging face surgery. With the recent surge in popularity of fat grafting, we seek to re-establish the minimal incision endoscopic midface lift as the definitive procedure in restoring one’s own volume to the midface. The surgical technique will be highlighted, in a step-by-step
fashion, focusing on intra-operative modifications based on individual patient anatomy. Pearls and potential pitfalls will be shared. For the two instructors, the endoscopic midface lift is the procedure of choice in correcting adverse sequelae of prior facelifts.

**Learning Objectives:** At the conclusion of the course, participants should be able to: 1) formulate a surgical technique for the endoscopic midface lift with buccal fat suspension in a step-by-step fashion; 2) Describe the surgical and aesthetic indications for performing this procedure; 3) identify pearls and pitfalls associated with this procedure; and 4) recognize the value of the endoscopic midface lift in the revision facelift patient population.

**IC77 New Approaches to Periorbital Rejuvenation (Grand E)**

Richard D. Gentile, MD

**Summary:** A review of new approaches to rejuvenation of the forehead brow and eyes emphasizing new surgical approaches including minimal access browplasty and brow lift. The course also describes new approaches to lower lid blepharoplasty including pinch excisions and simultaneous fat grafting. The safe concurrent use of periorbital laser skin rejuvenation is also reviewed.

**Learning Objectives:** At the conclusion of the course, participants should be able to: 1) describe the various approaches to brow and forehead lifting including endoscopic and non endoscopic techniques; 2) discuss the complexities of lower lid rejuvenation and the benefits of concurrent fat grafting in operative techniques; and 3) recognize the necessity for lower lid contour adjustments in 3D for lower lid eyelid rejuvenation.

**IC78 Short Flap/Modified Face Lifting Procedure Using Level 1 Local Anesthesia in an Office Setting Emphasis On Patient Safety and Satisfaction Scores (Nottaway)**

John A. Standefer Jr., MD and Jason Swerdloff, MD

**Summary:** Short flap facelifts have become the standard of practice in most facial plastic surgery practices. With ever increasing emphasis on patient safety and satisfaction, our technique for excellent results using Level 1/local anesthesia is presented. Patient satisfaction scores are reviewed both with the pain levels experienced during and after the procedure. We show decreased risks from those associated with general anesthesia associated with facial procedures, and an overall cost savings to the patients. Our combined experience of over 8,000 office-based facial procedures is presented.

**Learning Objectives:** At the conclusion of the course, participants should be able to: 1) understand that facelifts can be safely performed in an office setting using local and oral anesthesia with a high degree of patient satisfaction using standard short flap techniques; and 2) increase patient satisfaction, lower their costs of facial procedures, and reach a wider patient base.

**IC79 Why Should I Pay More for My Internet Marketing Strategy? (Borgne)**

David Evans, PhD (Non CME)

**Summary:** Due to the confusion related to Internet marketing, many practices simply choose the lowest cost supplier to perform key tasks. This strategy has backfired on many practices, actually creating more expense to fix the problems created by the lowest bidder. To aid in making a more educated selection of vendors for Internet marketing, this course will provide detailed information about the key factors related to successful strategies for search engine optimization, social media and blogging and how to determine if paying more will pay off for your practice.

**Learning Objectives:** At the conclusion of the course, participants should be able to: 1) understand the basic components of Search Engine Optimization (SEO) and how Google uses these components to rank practice web sites; 2) understand the proper content selection and structure of blog posts to maximize consumer interest and patient conversion; 3) describe the most important aspects of a successful social media strategy, with the key focus on building interaction with the patient base of the practice; and 4) create a list of the proper questions to ask a vendor to determine whether the value you expect from the Internet packages being offered can be delivered for the price quoted.

**IC80 Cartilage Repositioning Rhinoplasty: An Extension of the Tripod/Pedestal Concept (Chenier)**

Howard D. Stupak, MD

**Summary:** The tripod/pedestal concept is the predominant theory of nasal tip rotational dynamics used by plastic surgery. Traditionally, projection and/or tip rotation are achieved via strengthening (grafting) or weakening (cartilage division) of the limbs of the tripod. Beyond this, interaction of the medial and lateral crura, with their surrounding support structures including the upper lateral cartilages, supportive mucosa and septal L-struct can also significantly affect the three dimensional position of the tripod (rotation and projection). This course will describe these relationships in detail, and the critical consequences of modification of these interactions in rhinoplasty and nasal valve surgery. Finally, history, approaches, operative details, challenges, and aesthetic and functional outcomes will be discussed.

**Learning Objectives:** At the conclusion of the course, participants should be able to describe the detailed interaction of the tripod with its supportive surrounding structures and recall maneuvers that permit modification of these interactions during rhinoplasty and nasal valve surgery.

**IC81 Treatment and Reconstruction of Advanced Basal Cell Carcinoma of the Face (Couteau)**

P. Daniel Knott and Rahul Seth, MD

**Summary:** Treatment of advanced basal cell carcinoma of the face has evolved with the development of several targeted molecular therapies. This course will review the evidence for a multidisciplinary treatment paradigm for advanced basal cell carcinoma and make recommendations for optimal therapy. Reconstructive strategies and novel approaches for the treatment of advanced cutaneous malignancies will also be covered.

**Learning Objectives:** At the conclusion of the course, participants should be able to define the novel hedgehog inhibitors and their role in the treatment of advanced basal cell carcinoma and describe the most useful techniques for reconstructing advanced facial cutaneous malignancies.
when planning surgical correction. Also focus on preserving orbicularis tone and volume augmentation (eyelid laxity, negative vector, and eyelid scarring) surgeons should add to focusing on the traditionally accepted causes of post-contributors than previously thought. The data suggests that orbicularis weakness and volume deficit are likely more important factors. The authors found that orbicularis retraction was 2.3 mm, with a trend for more retraction in patients with more etiological causes.

**Conclusions:** Lower eyelid retraction after blepharoplasty is a multifactorial problem. The authors found that orbicularis weakness, infraorbital volume deficiency, negative eyelid vector, eyelid laxity, and lamellar shortage are all frequently present. Lower eyelid tether to the orbital rim is less common, and orbicularis weakness and volume deficit are likely more important contributors than previously thought. The data suggests that in addition to focusing on the traditionally accepted causes of post-blepharoplasty lower lid retraction (anterior lamellar shortage, eyelid laxity, negative vector, and eyelid scarring) surgeons should also focus on preserving orbicularis tone and volume augmentation when planning surgical correction.

**Abstract Body:** Lower eyelid retraction after blepharoplasty has historically been associated with a transcutaneous approach, unaddressed eyelid laxity, overzealous excision of skin, and middle lamellar scarring. Planning surgical correction of this complex eyelid malposition requires a detailed evaluation and identification of the etiologic factors contributing to its presence on initial evaluation.

**Objective:** 1. Conduct a physical exam to identify all of the etiological factors that might be contributing to a patient’s post-blepharoplasty lower lid retraction; 2. Better appreciate the role that orbicularis oculi weakness and volume deficit play in post-blepharoplasty lower lid retraction.
Endoscopic Forehead Lift: Experience Over an 18-year Period
Heather H. Waters, MD and Stephen W. Perkins, MD

Core Competencies: (Patient Care, Practice-based Learning and Improvement)

Level of Evidence: Outcomes Research

Method: Eighteen-year retrospective evaluation of 540 patients undergoing endoscopic forehead lift by a single surgeon using a modified technique. Medical charts were reviewed for postoperative complications and the duration of complaints. Photographic preoperative, initial and long-term postoperative measurements of eyebrow-to-eye and eyebrow-to-pretrichial distances were obtained. The use of intraoperative and postoperative neurotoxins was reviewed. Evaluations by blinded colleagues were obtained from preoperative and postoperative photographs.

Results: Five hundred and forty patients undergoing endoscopic forehead lift between 1994 and 2012 were evaluated. Complications reviewed included pain, nausea, hematoma, parasthesias, pruritus, asymmetry and alopecia. Mean medial canthus, mid-pupil, and lateral canthus-to-brow elevation was 5.9, 5.4 and 4.4 mm after surgery respectively, with symmetry in contralateral measurements. Long term follow up demonstrated continuous brow height with a mean increase of brow-to-pretrichial distances of 0.5mm per year. Conclusion: Endoscopic forehead lift provides long lasting results. This unique large series retrospective chart review validates the long-term benefits of this procedure and reinforces the use of tan adapted technique in the enhancement of cosmetic and functional brow ptosis.

Objective: At the conclusion of this presentation, the participants should be able to describe the quantitative and qualitative long-term results of the endoscopic forehead lift as well as describe an adapted technique to achieve sustained benefits.

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Postoperative antibiotic ointment is prescribed after upper blepharoplasty by 55.1% (76/138) of respondents, while a postoperative oral antibiotic is prescribed by 61.8% (84/136). The central fat pad is almost never removed during upper blepharoplasty (0.8%, 1/131), while all fat pads are “sometimes” excised in lower lid surgery (nasal 91.1%, central 91.9%, lateral 97.6%). Few reported performing fat repositioning during upper lid blepharoplasty (8.9%, 12/135), while the majority reported repositioning fat during lower lid blepharoplasty (65.6%, 86/131). Surveying the current trends in the approach to upper and lower lid blepharoplasty by AAFPRS members revealed a number of interesting practice trends that are of value to current and future facial plastic surgeons.

Objective: 1. Discuss current trends in upper blepharoplasty including excision of orbicularis muscle versus preservation, and excision of fat pads 2. Evaluate current trends for lower lid blepharoplasty including incisions used, fat pad repositioning or excision 3. Compare and contrast post operative blepharoplasty followups and care

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Refining the Results of Aging Face Surgery with Hair Transplantation Techniques
Gorana Kuka, MD; Jeffrey Epstein, MD; and Anthony Bared, MD

Core Competencies: (Patient Care, Practice-based Learning and Improvement)

Level of Evidence: Case Series

Method: The senior author has performed over 9,000 hair transplantation procedures. Some of these procedures have been performed on patients with aging face concerns, who seek to have greater hair density and/or a lower hairline as part of achieving a more youthful appearance. In addition, over 500 procedures were performed to repair the unaesthetic scarring and hairline distortion from prior facelift and browlift surgeries.

Results: Over 1,500 hair procedures over the past 18 years were effectively performed to address hair concerns in aging face patients as well as to repair the scarring and hairline distortion from prior aging face concerns.

Conclusions: Consistent aesthetic results can be achieved in using hair transplantation techniques both as part of treating the aging face, as well as repairing the unaesthetic scarring and hairline distortion that can result from some of these aging face surgeries.

Abstract Body: There are a variety of ways in which hair restoration surgery can play a role in the management of the aging face patient. The first is in addressing hair loss concerns in these patients, some of which can be done simultaneously with the aging face surgery, others that are best done at a separate time. These may include complaints of overly high hairlines, receded frontotemporal recessions, and/or inadequate overall density. The second is in improving the hairline distortion and/or alopecic scarring that can result from prior browlifts and facelifts. Hair transplantation techniques as well as the Surgical Hairline Advancement procedure can be utilized in these cases, however this requires understanding of the techniques available, and how
Objective: To more objectively evaluate the impact of aesthetic facial surgery on perceived age and attractiveness.

Abstract Body: PURPOSE: A primary intention of patients seeking aesthetic facial surgery is to look younger and more attractive. However, there is minimal literature on the impact of aesthetic facial surgery on perceived age and attractiveness. Here we sought to objectively evaluate the degree of perceived age change and attractiveness following aesthetic facial surgical procedures. To more objectively evaluate the impact of aesthetic facial surgery on perceived age and attractiveness. METHOD: Of the total of 204 patients who underwent primary facial surgical procedures between July 2006 and July 2010, 49 patients met the inclusion criteria and were selected for analysis. These forty-nine patients contributed a total of 196 standardized photographs (4 photos per patient: preoperative and postoperative; frontal and right lateral views for each). These photographs were presented to 50 blinded layperson raters, each having been randomly assigned to four separate rater groups. Raters were asked to estimate the age of each patient photograph presented and to rate the patients' attractiveness on a scale of 1-10.

RESULTS: The mean age of the patients was 57 (range: 42-73), with 37 (75.5%) patients being female. The mean overall years saved following aesthetic facial surgery was 3.1 years (range: 4.0–9.4 years). Scores decreased with patient age and increased with rater age, albeit not reaching statistical significance. Moreover, although patient attractiveness was inversely related to patient age, attractiveness scores did not change with surgery even after controlling for age and procedure.

Conclusions: Aesthetic facial surgery was observed to be effective in reducing the apparent age of patients but not consistently improve their attractiveness.
Room 2 - Aging Face
(Bourge)
Redefining Relationships in the Mid-Face: New Concepts for the Surgical Anatomy of the SMAS, Deep Fascia, the Facial Nerve, and Muscles
Chiara Andretto Amodeo, MD; Andrea Casasco, MD; Rahul Seth, MD; Robert Kang, MD; Gregory S. Keller, MD
Core Competencies: (Medical Knowledge, Practice-based Learning and Improvement)
Level of Evidence: Case Series
Method: 36 hemifaces in 18 Caucasian cadavers were dissected to define the relationships of this deep fascia with the superficial musculo-aponeurotic system (SMAS), facial muscles, and facial nerve in the midface
Results: The zygomatic major and the muscles forming the “lifting system of the upper lip” are covered by a deep fascial plane continuous with the superficial layer of the deep temporal fascia and not by the Smas. The Smas and this deep fascial layer coalesced caudal to these muscles. This layer was in continuity to the parotid fascia at the anterior border of the parotid gland and remained superficial to the facial nerve.
Conclusions: These dissections demonstrate that the fascial layers of the midface are different than previously described. Unlike previous authors, we note that there is a deep fascial layer in the midface that is continuous with the temporal and prezygomatic areas and protects the buccal branch of the facial nerve. The zygomaticus muscles are covered by this deep fascia, not by the Smas, as classically described. These findings carry surgical implications in deep plane and subperiosteal facelifting with avoidance of the facial nerve.
Abstract Body: Introduction Our recent dissections of the midface demonstrate that the fascial layers in this area are different than previously described. Unlike previous authors, we note that there is a deep fascial layer in the midface that is continuous with the temporal and prezygomatic areas. These findings carry surgical implications in deep plane and subperiosteal facelifting, and can be useful to effective surgery and avoidance of the facial nerve.
Materials and Methods: 36 hemifaces in 18 Caucasian cadavers were dissected to define the relationships of this deep fascia with the superficial musculo-aponeurotic system (SMAS), facial muscles, and facial nerve in the midface. Results: The zygomatic major and the muscles forming the “lifting system of the upper lip” are covered by a deep fascial plane continuous with the superficial layer of the deep temporal fascia and not by the Smas. The Smas and this deep fascial layer coalesced caudal to these muscles. This layer was in continuity to the parotid fascia at the anterior border of the parotid gland and remained superficial to the facial nerve.
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Objective: Learn that the fascial layers in the midface are different than previously described; use the new anatomic findings in deepplane and subperiosteal faceliftin.
of skin slough (4%). There was limited incidence of minor hematoma (3%), and there were no major hematomas or revisions. Conclusions: Deep plane facelift surgery in smokers results in a low incidence of skin slough and complications. Despite counseling to discontinue smoking, patients continued to smoke peri-operatively to varying degrees. This flap exhibited high perfusion despite underlying smoking related vaso-occlusive disease and continued tobacco use peri-operatively. The success with deep plane surgery technique supports anatomic cadaver studies, which suggest greater perfusion to the flap in deep plane facelift surgery. Since vaso-occlusive disease in smokers is a constant concern for facelift surgeons, deep-plane technique provides a safe option.

**Objective:** Explain and discuss the advantages of deep-plane facelift technique for smoking patients; discuss literature review of success of facelift in smokers and the relevant vascular anatomic aspects of facelift flap in cadaveric studies.

### Sub SMAS Mobilization and Division with Significant Advantages in SMAS

**Douglas W. Halliday, PhD, MD**

**Core Competencies:** (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)

**Level of Evidence:** Outcomes Research

**Method:** 90 Patients undergoing sub-SMAS rhytidectomy, the SMAS advancement was measured before and after horizontal division of SMAS flap.

**Results:** There was significant additional SMAS mobilization with division which correlated with significant improvement in jaw contour and submental definition, without mouth distortion.

**Conclusions:** Mobilization of sub SMAS flap with horizontal division, allowed for significant advancement of the SMAS flap, which correlated with significant clinical improvement.

**Abstract Body:** 90 Patients undergoing rhytidectomy were organized in a prospective study, in which a sub SMAS flap was mobilized and advanced. Measurements were taken at this point and the flap was divided horizontally into an anterior and posterior flap, the increased advancement in the SMAS advancement was then measured on both left and right sides, and average additional advancement was calculated. This seemed to correlate with significant improvement in both the jaw line and submental definition.

**Objective:** Understand how they can further improve the quality of the patient’s neck and submental lift with minimal additional effort, be able to use the results of this study with their own experience, and use their expert opinion to determine if this can be applied to their method of practice.

### Efficacy of Artiss in Rhytidectomy: A Prospective Randomized Study

**Lindsay S. Eisler, MD and Edward H Farrior, MD**

**Core Competencies:** (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)

**Level of Evidence:** Randomized Controlled Trial

**Method:** Artiss has recently been approved by the US Food and Drug Administration for application exclusively in rhytidectomy patients. Patients eligible for enrollment included all patients undergoing facelifts, necklifts and cheek lifts with or without additional procedures. Twenty-five patients were voluntarily, prospectively enrolled to participate. Patients were randomized to receive the tissue sealant to one side of the rhytidectomy. Two milliliters of Artiss was sprayed through a nitrogen pressure regulator between the subcutaneous skin flap and SMAS directly prior to skin closure. Deep sutures were placed to close the skin within one minute of spraying the Artiss. Gentle pressure was then applied to the skin for 3 minutes. No drains were placed, but a pressure dressing was placed post procedure and removed on the first post-operative day. Photographs were taken on post-operative day 1, 7, 14, 1 month and 3 months. Independent reviewers compared the post operative photographs. The reviewers were blinded as to which side received the Artiss. The photographs were scrutinized for level of ecchymosis and edema. The results were compared.

**Results:** Artiss was found to reduce ecchymosis and edema of post operative rhytidectomy patients. There were no hematomas for either side documented for the 25 patients. There were no known long-term complications from either the use of Artiss or the rhytidectomy.

**Conclusions:** Artiss is advantageous for reducing post operative ecchymosis and edema in rhytidectomy patients.

**Abstract Body:** **OBJECTIVE:** To examine the potential efficacy of Artiss in patients undergoing rhytidectomy to evaluate for a decrease in amount of ecchymoses, incidence of hematoma and overall speed of recovery. **METHODS:** Artiss has recently been approved by the US Food and Drug Administration for application exclusively in rhytidectomy patients. Patients eligible for enrollment included all patients undergoing facelifts, necklifts and cheek lifts with or without additional procedures. Twenty-five patients were voluntarily, prospectively enrolled to participate. Patients were randomized to receive the tissue sealant to one side of the rhytidectomy. Two milliliters of Artiss was sprayed through a nitrogen pressure regulator between the subcutaneous skin flap and SMAS directly prior to skin closure. Deep sutures were placed to close the skin within one minute of spraying the Artiss. Gentle pressure was then applied to the skin for 3 minutes. No drains were placed, but a pressure dressing was placed post procedure and removed on the first post-operative day. Photographs were taken on post-operative day 1, 7, 14, 1 month and 3 months. Independent reviewers compared the post operative photographs. The reviewers were blinded as to which side received the Artiss. The photographs were scrutinized for level of ecchymosis and edema. The results were compared. **RESULTS:** Artiss was found to reduce ecchymosis and edema of post operative rhytidectomy patients. There were no hematomas for either side documented for the 25 patients. There were no known long-term complications from either the use of Artiss or the rhytidectomy. **CONCLUSION:** Artiss is advantageous for reducing post operative ecchymosis and edema in rhytidectomy patients.

**Objective:** To examine the potential efficacy of Artiss in patients undergoing rhytidectomy to evaluate for a decrease in amount of ecchymoses, incidence of hematoma and overall speed of recovery.

### Quantitative Assessment of the Role of Sculptra Aesthetic In Mid-Facial Rejuvenation

**Pardis Javadi, MD; Henry H. Chen, MD; Steven Daines, MD; and Edwin F. Williams III, MD**

**Core Competencies:** Patient Care

**Level of Evidence:** Cohort Study

**Method:** A prospective study was carried out in 15 female receiving Sculptra Aesthetic to the midface complex for a total of three treatments. The first two treatments were each 6 weeks apart. The third treatment was at 12 weeks from the second
**FREE PAPER ABSTRACTS**

Treatment. Three-dimensional imaging was acquired using a Canfield Scientific Vectra camera and software, with quantitative volume measurements evaluating the amount of post treatment volume change. These three-dimensional images were obtained prior to treatment and at 12, 24, 36, and 48 weeks following the third treatment.

**Results:** Fifteen female patients between ages 40-60 were included in this study. One patient only received two treatments and therefore was excluded from the statistical analysis. There was a statistically significant increase in mean facial volume at all study time points, 12 weeks (mean 7.2 ml; P = 0.0007), 24 weeks (mean = 7.1 ml; P = 0.0007), 36 weeks (mean = 4.6 ml; P = 0.001), and 48 weeks (mean = 4.1 ml; P = 0.0004), compared to pre-treatment volume. There was no significant change in volume between each of the follow-up time points, despite a significant increase in volume from the baseline at each time point.

**Conclusions:** Our investigation quantitatively demonstrates the efficacy of Sculptra Aesthetic as a long acting volumizing agent, as the increase in midfacial volume observed at early time-points is sustained at later time-points.

**Abstract Body:** The goal of this study is to demonstrate quantitatively using three-dimensional imaging, the efficacy and longevity of Sculptra Aesthetic as a volumizing injectable in the midface region.

**Objective:** Assess the role of Sculptra Aesthetic in the rejuvenation of the mid-face complex.

**The Aesthetic Unit Principal of Facial Aging**

Susan L. Tan, B.Sc(Hon), MD; Michael G. Brandt, MD; FRCSC, Philip C. Doyle, PhD, and Corey Moore, MD; MSc, FRSCSC, FACS

**Core Competencies:** (Patient Care, Practice-based Learning and Improvement)

**Level of Evidence:** Randomized Controlled Trial

**Method:** Photographs of seven adult females were prepared for experimental evaluation of the presence or absence of facial aesthetic unit separation. Photo stimuli were then presented to naive observers in a blinded paired comparison (PC) evaluation. For each stimulus pair, observers were asked to select the face which they considered as more youthful in appearance. All stimuli were compared to all others. A preferential rank list was then generated from the most to the least youthful.

**Results:** 24 observers evaluated 224 pairs of photographs, thus generating 5376 responses for analysis. Faces without facial aesthetic unit separation were consistently judged to be more youthful than their original or modified counterparts. Additionally, and as a group, those faces that exhibited increasing aesthetic unit separation were ranked lowest on the preference rank list compared to photographs without aesthetic unit separation.

**Conclusions:** Our data support the hypothesis that facial aesthetic unit separation influences perceived facial youthfulness amongst female photographs. The presence of facial aesthetic unit separation results in a less youthful appearance. Based on these empirical data, the concept of the facial aesthetic unit separation appears to play a significant role in perceived facial aging.

**Abstract Body:** In youth, facial aesthetic units flow together without perceptible division. The face appears as one dynamic structure with a smooth facial contour and very little if any shadowing between different anatomical regions of the face. As one ages, facial aesthetic units slowly become separated from each other. This may be due to differences in skin thickness, composition of subcutaneous tissue, contour of the facial skeleton and location of facial ligaments. Although the impact of aesthetic unit separation is clinically apparent, its fundamental role in perceived facial aging has not yet been empirically defined. This investigation sought to demonstrate and define the impact of aesthetic unit separation on facial aging and, consequently, empirically validate the rationale for blending of aesthetic units as a principle for facial rejuvenation.

**Objective:** (1) To evaluate the impact of facial aesthetic unit separation on perception of age (2) To propose the blending of facial aesthetic unit as a principle for facial rejuvenation.

**Room 3 - Minimally Invasive**

**Low Level Laser Light Therapy for Hair Loss: Analysis of Patient Survey**

Anthony Bare, MD and Jeffrey S. Epstein, MD; FACS

**Core Competencies:** (Medical Knowledge, Patient Care)

**Level of Evidence:** Outcomes Research

**Method:** Hypothesis: The use of LLLT is well-tolerated by hair loss patients and in the majority of cases is perceived by patients to help with their hair loss problem. Methods: A survey was sent to all LLLT patients in our office who use either the in-office laser or one of the at-home devices. The survey was emailed to all patients in our database who use the in-office laser device or one of the at-home laser devices. Responses to the survey were anonymous and voluntary. All patients have a history of hair loss.

**Results:** The survey was emailed to 500 patients and the data collection is presently on-going. The survey consisted of 10 questions whose responses include: 1. type of hair loss, 2. whether there was a history of hair transplant, 3. laser modality currently used, 4. use of a different laser in the past for hair loss, 5. concomitant use of hair loss medications, 6. duration of laser use, 7. compliance, 8. changes noted in hair shedding pattern, 9. changes noted in hair density, 10. patient recommendation of laser to others suffering from hair loss. Demographic data will be collected with the results. Statistical analysis of the survey data will be by chi-squared analysis.

**Conclusions:** Low level laser light therapy has been perceived by patients to positively affect their hair loss. In our practice, we have seen the benefits of LLLT for our patients through voluntary, anecdotal feedback as well as physician and technician observation. We recommend LLLT as an option for our patients who may want to avoid the potential side effects of pharmaceutical therapy, as a concomitant modality with pharmaceutical treatment, to patients who are not candidates for hair transplant surgery, or as an adjunctive post-operative modality after hair transplant surgery. We sought to study our anecdotal findings by means of a patient survey. The survey allows for the analysis of patient’s perception of how LLLT has affected their hair loss and better educates physicians treating hair loss in managing patient expectations.

**Abstract Body:** Introduction: Hair loss comes in many forms, the most common of which is androgenic alopecia which affects roughly 40% of women and 70% of men to some degree at some point in their lifetime. Pharmacologic and surgical options were the only viable treatment options for patients with thinning hair until recently, with low level laser light therapy (LLLT) gaining in popularity. LLLT has been used for non-hair indications, and when applied for the treatment of cutaneous lesions, was found to have the side effect of paradoxical hypertrichosis. When delivered between the 650 to 900 nm wavelengths at 5 mW, it has been...
Black Light Assessment of Surgical Trainees for Facial Reconstruction

Javad Sajan, MD; Javad Sajan, MD; Peter Hilger, MD; William Walsh, MD; David Shaye, MD; Troy Reihisen, and Robert Sweet, MD

Core Competencies: (Patient Care, Practice-based Learning and Improvement)

Level of Evidence: Randomized Controlled Trial

Method: A 3D organosilicate model of a human adult face was created with imbedded relaxed skin tension lines that are only visible under black light. Surgical specialty trainees from six institutions prospectively drew a z-plasty on the right side of the model and then performed a z-plasty on the left side of the model where the black light technology was imbedded. Subjects were blinded to the presence of the imbedded black light relaxed skin tension lines. Four reviewers that were blinded to the identity and postgraduate training level of the subject rated the drawing and the result of performing the z-plasty under black light visualization of the relaxed skin tension lines. Under black light visualization the raters measured the position of the limbs of the z-plasty relative to the relaxed skin tension lines and the raters measured the distortion of the relaxed skin tension lines that occurred from the z-plasty.

Results: We were able to successfully create a 3D organosilicate model of a human adult face that incorporated relaxed skin tension lines that are only visible under black light. Forty-three trainees encompassing 3 PGY1, 10 PGY2, 13 PGY3, 11 PGY4, 3 PGY5, and 3 PGY6(fellows) completed the study. Subjects were placed into three groups: novices(PGY1 PGY2), intermediates(PGY3 PGY4), and experts(PGY5 PGY6). Experts performed statistically better (p<.05) than intermediates and intermediates better than novices (p<.05) for drawing the z-plasty on the model and performing the z-plasty on the model. This statistically significant difference between groups showed substantial inter-rater reliability agreement among the four raters with an average Cohen’s Kappa=0.73. Conclusion: We have created a model for black light assessment of surgical trainees in facial reconstruction that is valid and shows high inter-rater reliability among four blinded raters. Black light visualization improved the analysis of the reconstruction as the subjects were not allowed to see the relaxed skin tension lines while the reviewers’ evaluation included the black light visualization of the relaxed skin tension lines. This provided graphic demonstration of the relationship between the incisions, relaxed skin tension lines, and the tissue distortion created by the work of the subject.

Objective: At the conclusion of this activity, the participant should be able to discuss how black light technology is implemented in a synthetic model to teach facial reconstruction. At the conclusion of this activity, the participant should be able to discuss how black light technology is implemented in a synthetic model to teach facial reconstruction. At the conclusion of this activity, the participant should be able to discuss how black light technology is implemented in a synthetic model to teach facial reconstruction. The participant should be able to compare and contrast the utility of black light technology to assess facial reconstruction in surgical trainees.

Methods: A 3D organosilicate model of a human adult face was created with imbedded relaxed skin tension lines that are only visible under black light. Surgical specialty trainees from six institutions prospectively drew a z-plasty on the right side of the model and then performed a z-plasty on the left side of the model where the black light technology was imbedded. Subjects were blinded to the presence of the imbedded black light relaxed skin tension lines. Four reviewers that were blinded to the identity and postgraduate training level of the subject rated the drawing and the result of performing the z-plasty under black light visualization of the relaxed skin tension lines. Under black light visualization the raters measured the position of the limbs of the z-plasty relative to the relaxed skin tension lines and the raters measured the distortion of the relaxed skin tension lines that occurred from the z-plasty.

Pre-Made Fixation Plates for the Endoscopic Assisted Transoral Approach to Orbital Rim Fractures

Todd M Brickman, MD, PhD, FACS, Anita Jeyakumar, MD, FACS, and Samuel Muller

Core Competencies: Patient Care

Level of Evidence: Case Series

Method: A cadaveric study was conducted in investigator created 10 midface facial fracture specimens that had orbital rim fractures and a concomitant midface lefort or ZMC fracture. All specimens had open reduction internal fixation (ORIF) of midface facial
fractures (medial and lateral buttress, and orbital rim) through a transoral approach utilizing endoscopic assistance. The zygomatic-frontal (ZF) suture line fractures were repaired through a superior blepharoplasty incision. Orbital rim ORIF was accomplished with premade “dipper” fracture plate. The plates were fabricated to be positioned laterally on the orbital rim and then course inferiorly to the inferior orbital nerve (ION) and medially fixated to the medial buttress bridging the orbital rim fracture. Analysis of fracture reduction and fixation through the transoral approach was evaluated with a traditional open incision to the orbital rim.

Results: All specimen orbital rim fractures were able to be reduced and fixated through a transoral approach with endoscopic assistance. The dipper plate that courses inferior to the infraorbital rim had acceptable reduction and stable fixation of orbital rim fractures with cosmetically acceptable results. A traditional open approach to the orbital rim confirmed that the premade dipper plates provided adequate fixation and stability at appropriate anatomical landmarks of the orbital rim and the midface medial buttress.

Conclusions: A transoral endoscopic approach for carefully selected midface fractures involving the orbital rim is feasible with acceptable reduction and stable fixation. The “dipper” plate provides a quick prefabricated plate that can be stacked in midface platting systems that spans orbital rim fractures to provide acceptable results. Future work is needed to evaluate the plates in in-vivo environments.

Abstract Body: 1. Evaluate the feasibility of using premade “dipper” fixation plates in the purely transoral approach to infraorbital rim fractures utilizing endoscopic assistance. 2. Analyze the patient outcomes of cosmesis and the success rate of reduction and fixation using a premade “dipper” fixation plate. A cadaveric study was conducted in investigator created 10 midface facial fracture specimens that had orbital rim fractures and a concomitant midface LeFort or ZMC fracture. All specimens had open reduction internal fixation (ORIF) of midface facial fractures (medial and lateral buttress, and orbital rim) through a transoral approach utilizing endoscopic assistance. The zygomatic-frontal (ZF) suture line fractures were repaired through a superior blepharoplasty incision. Orbital rim ORIF was accomplished with premade “dipper” fracture plate. The plates were fabricated to be positioned laterally on the orbital rim and then course inferiorly to the inferior orbital nerve (ION) and medially fixated to the medial buttress bridging the orbital rim fracture. Analysis of fracture reduction and fixation through the transoral approach was evaluated with a traditional open incision to the orbital rim. Results: All specimen orbital rim fractures were able to be reduced and fixated through a transoral approach with endoscopic assistance. The dipper plate that courses inferior to the infraorbital rim had acceptable reduction and stable fixation of orbital rim fractures with cosmetically acceptable results. A traditional open approach to the orbital rim confirmed that the premade dipper plates provided adequate fixation and stability at appropriate anatomical landmarks of the orbital rim and the midface medial buttress. Conclusion: A transoral endoscopic approach for carefully selected midface fractures involving the orbital rim is feasible with acceptable reduction and stable fixation. The “dipper” plate provides a quick prefabricated plate that can be stacked in midface platting systems that spans orbital rim fractures to provide acceptable results. Future work is needed to evaluate the plates in in-vivo environments.

Objective: 1. Evaluate the feasibility of using premade “dipper” fixation plates in the purely transoral approach to infraorbital rim fractures utilizing endoscopic assistance; analyze the patient outcomes of cosmesis and the success rate of reduction and fixation using a premade “dipper” fixation plate.

Multicentre Study for Acute Resurfacing Wound Care with Hypochlorous Acid Solution
Basil Hassounen, MD and James P. Newman, MD
Core Competencies: (Medical Knowledge, Patient Care)
Level of Evidence: Randomized Controlled Trial
Method: This is a prospective multi-center study recruiting consecutive patients for participation. All patients had LASER or chemical skin resurfacing with a standardized post-resurfacing care. The toleration of the topical treatment, erythema, exudates, re-epithelialization and skin infection were evaluated at post-resurfacing days 3, 7 and 14.

Results: There were 22 control patients using saline and 24 patients using HA solution. All patients tolerated the topical solution well with no sensitivity, burning or ocular irritation. There was no statistically significant difference between the control and HA groups regarding wound healing, erythema or exudates scores, although HA was associated with higher wound care comfort. There were no skin infections in both groups.

Conclusions: In patients with skin resurfacing, HA solution is well tolerated and not associated with sensitivity, burning or ocular irritation. It has the advantage of a wide-spectrum antimicrobial activity without promoting resistance or causing systemic or toxic side effects. A larger patient recruitment is needed to evaluate if HA can improve erythema or wound healing and effectively decrease the risk of skin infection.

Abstract Body: Introduction and Objectives: Skin resurfacing is a common procedure used to improve skin quality, rhytides and acne scars. There is an important risk for skin infection which impedes healing or cause scarring. Although there are no accepted standards for post-resurfacing care, many practitioners prescribe prophylactic oral antibiotics during the re-epithelialization stage. This practice can increase bacterial resistance or cause systemic side effects. Hypochlorous acid (HA) is a bactericidal compound that is naturally present in the human biological system and works against a wide rage of microorganisms. It is non-toxic and not associated with bacterial resistance. Furthermore, it has a suggested role in collagen cross linking. The objective of this study is to evaluate the tolerance and wound healing with topical HA solution compared to saline. Methods: This is a prospective multicenter study recruiting consecutive patients for participation. All patients had LASER or chemical skin resurfacing with a standardized post-resurfacing care. The tolerance of the topical treatment, erythema, exudates, re-epithelialization and skin infection were evaluated at post-resurfacing days 3, 7 and 14. Results: There were 22 control patients using saline and 24 patients using HA solution. All patients tolerated the topical solution well with no sensitivity, burning or ocular irritation. There was no statistically significant difference between the control and HA groups regarding wound healing, erythema or exudates scores, although HA was associated with higher wound care comfort. There were no skin infections in both groups. Conclusion: In patients with skin resurfacing, HA solution is well tolerated and not associated with sensitivity, burning or ocular irritation. It has the advantage of a wide-spectrum antimicrobial activity without promoting resistance or causing systemic or toxic
side effects. A larger patient recruitment is need to evaluate if HA can improve erythema or wound healing and effectively decrease the risk of skin infection.

**Objective:** Discuss acute post-resurfacing wound care, and the role of hypochlorous acid as a topical solution. Discuss stepped wedge cluster randomized study design, and outcome evaluation in post skin resurfacing care.

**Plastic Surgery Digital Photograph Management using Adobe Lightroom**

William E. Walsh, MD and Phil Chaffin, MD

**Core Competencies:** (Medical Knowledge, Patient Care, Practice-based Learning and Improvement, Systems-based Practice)

**Level of Evidence:** Case Series

**Method:** Retrospective review of the digital photographic management and uses of clinical photographs taken by a single surgeon in an academic facial plastic and reconstructive surgery practice and cataloged into Adobe Lightroom during a 3-year period.

**Results:** 44,851 clinical photographs were obtained and cataloged during a 3-year period. The workflow and folder structure described in the study allowed inclusion of all clinical photographs, from multiple cameras, in multiple clinical settings. Common keywording strategies were identified. Lightroom’s functionalities allowed a variety of purposes including: quality improvement, education, documentation, communication, and morphing. Compared to other photo management software used in our department, Lightroom allowed many vital functions that the electronic medical record (EMR) could not perform.

**Conclusions:** Lightroom and the organizational structure used in this study allowed effective clinical digital photo organization. Clinical photographs organized in Lightroom served as a valuable teaching tool. This study also showed that the current EMR cannot adequately manage clinical photos to meet the standard of care in facial plastic and reconstructive surgery.

**Objective:** Discuss the methods of cataloging photographs in Adobe Lightroom for facial plastic surgery photo management and compare Lightroom’s organizational structure to other photo management systems.

A Comparison of the Rheological Properties of an Adipose Extracellular Matrix Biomaterial and Aspirated Adipose Tissue

Amid Kochhar, MD; Iwen Wu, PhD, Alexandra Conde-Green, Raja Mohan, MD; Alexander Hillel, Patrick Byrne, MD; and Jennifer Elisseff

**Core Competencies:** Medical Knowledge

**Level of Evidence:** Case Series

**Method:** The viscoelastic properties of lipoaspirate acquired from aesthetic liposuction (n=4) and acellular adipose derived ECM (n=4), were compared according to dynamic frequency oscillation measurements conducted using an ARES-G2 Rheometer (TA Instruments, DE). All measurements were performed using serrated 25 mm parallel plate geometry with a 1.0 mm gap at 37°C. Oscillation measurements were taken over a frequency range of 0.01 to 100 Hz.

**Results:** The $G'$ elastic (storage) modulus of the adipose-derived extracellular matrix was 713.2 ± 42.9 Pa with a complex viscosity of 61.5 ± 10.7 Pa·s at a frequency of 1 Hz. The aspirated adipose tissue had a $G'$ elastic (storage) modulus of 382.1 ± 66.8 Pa and a complex viscosity of 61.5 ± 10.7 Pa·s, a difference that was statistically significant ($p < 0.05$).

**Conclusions:** In comparison to lipoaspirate, adipose-derived ECM provides increased resistance to mechanical deformation, while retaining the native architecture and bioactivity of the original adipose tissue it is derived from. The rheological properties of the adipose-derived matrix make it an ideal soft tissue replacement for the repair of contour defects.

**Abstract Body:** Acquired soft tissue injury with resultant volume loss may cause significant deformity in size, shape and contour. Current autologous fat transfer techniques have a number of limitations that include availability, donor site morbidity, and unpredictable rates of resorption. We present an ECM biomaterial derived from human adipose tissue as an “off-the-shelf” alternative for soft tissue reconstruction.

**Objective:** At the conclusion of this presentation participants should be able to discuss the biomechanical properties of a novel soft tissue filling agent, adipose-derived extracellular matrix (ECM), and compare it to aspirated adipose tissue.

Room 4 - Reconstructive (Nottaway)

Decompression and Transposition of the Intratemporal Facial Nerve to a Hypoglossal Nerve with Partial Neurotomy for Reanimation of the Paralyzed Face

Amid Kochhar, MD; Linda N. Lee, Sofia Lyford-Pike, and Kofi D. Boahene, MD

**Core Competencies:** (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)

**Level of Evidence:** Case Series

**Method:** Patients with complete facial nerve paralysis that presented to a single surgeon at a tertiary care center meeting criteria for facial nerve reanimation were identified. This new procedure was performed in 16 patients. A retrospective case review was performed to evaluate the effects of this technique on outcomes of facial symmetry at rest, improvement of oral commissure excursion, tongue dysfunction, synkinesis, and post-operative complications.

**Results:** Decompression of the intratemporal facial nerve with transposition to the hypoglossal nerve for facial reanimation was performed in 16 patients. All 16 patients had a partial neurotomy of the hypoglossal nerve. Nine of the 16 cases had end-to-side anastomoses performed proximal to the take off of the ansa cervicalis, and seven were performed distally. The median age was 49 years old (range, 8-70). The median duration of facial paralysis prior to treatment was 11.5 months (range, 1-33). Median follow up time was 24.5 months (Range, 7-55). Facial symmetry at rest improved in 12 patients. Oral commissure excursion also improved in 12 patients with a mean recovery time of 10.2 months. No patients experienced tongue dysfunction or synkinesis. One patient developed a dehiscence of their post auricular mastoidectomy incision which improved with local wound care.

**Conclusions:** Decompression and transposition of the intratemporal facial nerve to the hypoglossal nerve is a safe and effective procedure for facial reanimation. The additional length provided by utilizing the intratemporal segment of the facial nerve can help reduce the deficits associated with complete hypoglossal division or splitting, and avoid the need for a jump graft.

**Abstract Body:** The hypoglossal nerve has long been used as an axonal source for reinervation of the paralyzed face. Common techniques for recruitment of the hypoglossal nerve are complete division, jump grafting, and more recently, the nerve splitting technique. Complete division and transposition of the hypoglossal...
Objective: At the conclusion of this activity participants should be able to discuss the technique of facial nerve reanimation using decompression and transposition of the intratemporal facial nerve to the hypoglossal nerve for reanimation of the paralyzed face.

Method: A retrospective review was conducted of one surgeon's experience attempting closure of perforations with mucosal flaps over the past 10 years (January 2003 to January 2013). Patient characteristics, perforation size, surgical technique, and outcomes were determined.

Results: The review identified 163 patients. The male to female ratio was 1:1.4 and the average age was 51.6 years. The most common perforation etiologies were septal surgery and nasal trauma. The most common symptoms were obstruction/congestion, crusting, and epistaxis. Perforation size was based on vertical height. There were 17 small (0-4 mm), 103 medium (5-14 mm), and 43 large (>15 mm) perforations. The endonasal approach was used in all repairs with one exception. Temporalis fascia was used as the interposition graft for most (62.3%) repairs. Successful closure was achieved in 95.7% of patients. Sixteen patients who had a successful closure required surgical revision.

Conclusions: This review provides further evidence supporting surgical management of the patient with a septal perforation. A technique utilizing bilateral mucosal flaps, an interposition graft, and protective Silastic sheeting has a high probability of closure for selected perforations.

Abstract Body: To report a single surgeon's (SFB) experience with septal perforation repair utilizing bilateral mucosal flaps over the past 10 years. Background: Septal perforation management continues to challenge the rhinologic surgeon. There is increased interest in attempted surgical repair. Success rates exceeding 90% have been reported with techniques utilizing nasal mucosal flaps. We report our experience attempting perforation closure utilizing bilateral mucosal flaps, an interposition graft, and protective Silastic sheeting.

Objective: Apply a technique for septal perforation repair utilizing bilateral mucosal flaps and an interposition graft.

Mucosal Flap Repair of 163 Septal Perforations
Andy M. Courson, MD and Stephen F. Bansberg, MD

Core Competencies: (Patient Care, Practice-based Learning and Improvement)
Level of Evidence: Case Series

Method: A retrospective review was conducted of one surgeon's experience attempting closure of perforations with mucosal flaps over the past 10 years (January 2003 to January 2013). Patient characteristics, perforation size, surgical technique, and outcomes were determined.

Results: The review identified 163 patients. The male to female ratio was 1:1.4 and the average age was 51.6 years. The most common perforation etiologies were septal surgery and nasal trauma. The most common symptoms were obstruction/congestion, crusting, and epistaxis. Perforation size was based on vertical height. There were 17 small (0-4 mm), 103 medium (5-14 mm), and 43 large (>15 mm) perforations. The endonasal approach was used in all repairs with one exception. Temporalis fascia was used as the interposition graft for most (62.3%) repairs. Successful closure was achieved in 95.7% of patients. Sixteen patients who had a successful closure required surgical revision.

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Objective: Apply a technique for septal perforation repair utilizing bilateral mucosal flaps and an interposition graft.
FREE PAPER ABSTRACTS

Abstract Body: Sub-optimal aesthetic outcomes are common in microtia repair due to the technically demanding procedure. Electromechanical reshaping (EMR) is an emerging tissue reshaping modality that uses DC electrical fields and in situ redox reactions concentrated in areas of mechanical stress to produce shape change in cartilage. Previous studies have demonstrated viability and significant shape change at 6 and 12 weeks. Optimization of in vivo parameters to assess the long-term effects of this reshaped tissue within the host is necessary.

Objective: Evaluate electromechanical reshaping (EMR) as a method to alter and maintain the shape of costal cartilage and evaluate this animal model as a means to study emerging methods to reshape costal cartilage tissue.

Reconstruction of Facial Skin Defects with Split-thickness Skin Grafts from the Scalp
Matthew Voorman, MD and John L. Frodel, MD
Core Competencies: (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)
Level of Evidence: Case Series
Method: We reviewed 14 patients with facial skin defects whose reconstruction required more skin than could be harvested from more standard full-thickness skin grafting techniques and, accordingly, included a split-thickness skin graft harvested from adjacent scalp. Pre-operative and post-operative photographs were used to evaluate size of defect and final cosmetic result.

Results: While patients generally had good cosmetic outcomes, with excellent color matching relative to other distant donor sites, a major advantage of the scalp donor site was low donor site morbidity. Scalp donor sites are commonly re-epithelialized at 7-10 days postoperatively, and have low reported pain scores. There were no major complications.

Conclusions: Reconstruction of facial skin defects that require large skin coverage with split-thickness skin grafts can optimally be harvested from adjacent scalp skin, providing excellent cosmesis with low donor site morbidity.

Abstract Body: Facial skin defects are most commonly reconstructed using full-thickness skin grafts. When more skin is required than can be harvested from standard full-thickness skin graft techniques, split-thickness skin grafts optimally harvested from adjacent scalp skin will provide excellent color matching and low morbidity as compared to other distant donor sites.

Objective: Explain the benefits of scalp based split-thickness skin graft as a reconstructive modality for facial skin defects, noting advantages relative to traditional harvest sites.

Current Practice Patterns for Prescribing Antibiotics for Facial Fractures: Preliminary Results
Neerav Goyal, MD, MPH, Sebastian Brooke, MD, Brett Michelotti, MD, Daniel P. Henrichsen, DMD, Fred Fedok, MD, FACS, Donald Mackay, MD, and Thomas D. Samson, MD
Core Competencies: (Medical Knowledge, Systems-based Practice)
Level of Evidence: Outcomes Research
Method: A 14 question anonymous online-based survey was distributed via e-mail to members of the American Academy of Facial Plastic and Reconstructive Surgery targeted to members of the society that specifically managed facial fractures. Information regarding surgeon demographics including board certification, time in practice, location of practice were recorded. Additionally, information regarding the type of antibiotics used, timing of antibiotic administration and the specific fractures for which antibiotics were used was recorded for both operative and non-operative cases. The descriptive data was then summarized.

Results: 100 total respondents who classified themselves as “otolaryngologists” or “facial plastic surgeons” responded. 48 of these respondents have been in practice for 10 or less years, with the remainder ranging from 11 to greater than 30 years. The geographic distribution showed 32% of respondents practicing in the Northeast, 19% in the Midwest, 26% in the South, 17% in the West, and 6% in the Pacific. 100% of respondents indicated that they use antibiotics for some facial fractures, of which 64 members use for non-operative fractures. The most common non-operative fracture for which antibiotics were prescribed were for mandibular fractures of the dentate segment (51%) followed by frontal sinus fractures (37%). 6% of respondents indicated that they prescribed antibiotics for non-operative septal fractures. For operative fractures, 84 members use an antibiotic in the pre-operative period and 97 use in the peri- or post-operative period. 23 respondents use antibiotics for 24 hours or less, and the remaining 74 use antibiotics for a range between 3 and 14 days. For operative fractures, 82 respondents prescribe antibiotics for dentate mandibular fractures followed by between 74-76 respondents for any LeFort classification fracture or a frontal sinus fracture. The most common class of antibiotic used in the patient without a penicillin allergy was a cephalosporin (60%), followed by a cephalosporin (26%). For the penicillin allergic patient, clindamycin was used most commonly (78%).

Conclusions: To our knowledge, this is the first survey of facial plastic surgeons/otolaryngologists regarding the use of prophylactic antibiotics in facial fractures. Prophylactic antibiotic practice patterns for operative and non-operative fractures, duration of prophylaxis, remains varied, however all respondents indicate the use of an antibiotic for some facial fractures and almost all use them during the peri- or post-operative period. Mandibular fractures, specifically involving the dentate segment receive antibiotics in the practice of the majority of respondents in both the operative and non-operative settings. The minority of respondents use antibiotics for fractures for 24 hours or less. These preliminary results are a subset of a larger survey study which also includes the practice patterns of plastic surgeons as well as oral and maxillofacial surgeons.

Abstract Body: Background: Otolaryngologists and facial plastics surgeons are some of the specialists that manage facial fractures and facial trauma. Previous studies have evaluated the use of antibiotics and may demonstrate a benefit to 24 hours of peri-operative antibiotics in decreasing the risk of post operative infection. We aimed to determine the current practice patterns of members of the AAFPRS in treating facial fractures. Methods: A 14 question anonymous online-based survey was distributed via e-mail to members of the American Academy of Facial Plastic and Reconstructive Surgery targeted to members of the society that specifically managed facial fractures. Information regarding surgeon demographics including board certification, time in practice, location of practice were recorded. Additionally, information regarding the type of antibiotics used, timing of antibiotic administration and the specific fractures for which antibiotics were used was recorded for both operative and non-operative cases. The descriptive data was then summarized.

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FREE PAPER ABSTRACTS

the remainder ranging from 11 to greater than 30 years. The geographic distribution showed 32% of respondents practicing in the Northeast, 19% in the Midwest, 26% in the South, 17% in the West, and 6% in the Pacific. 100% of respondents indicated that they use antibiotics for some facial fractures, of which 64 members use for non-operative fractures. The most common non-operative fracture for which antibiotics were prescribed were for mandibular fractures of the dentate segment (51%) followed by frontal sinus fractures (37%). 6% of respondents indicated that they prescribed antibiotics for non-operative septal fractures. For operative fractures, 84 members use an antibiotic in the pre-operative period and 97 use in the peri- or post-operative period. 23 respondents use antibiotics for 24 hours or less, and the remaining 74 use antibiotics for a range between 3 and 14 days. For operative fractures, 82 respondents prescribe antibiotics for dentate mandibular fractures followed by between 74-76 respondents for any LeFort classification fracture or a frontal sinus fracture. The most common class of antibiotic used in the patient without a penicillin allergy was a cephalosporin (60%), followed by a penicillin (26%). For the penicillin allergic patient, clindamycin was used most commonly (78%). Conclusion: To our knowledge, this is the first survey of facial plastic surgeons/ otolaryngologists regarding the use of prophylactic antibiotics in facial fractures. Prophylactic antibiotic practice patterns for operative and non-operative fractures, duration of prophylaxis, remains varied, however all respondents indicate the use of an antibiotic for some facial fractures and almost all use them during the peri- or post-operative period. Mandibular fractures, specifically involving the dentate segment receive antibiotics in the practice of the majority of respondents in both the operative and non-operative settings. The minority of respondents use antibiotics for fractures for 24 hours or less. These preliminary results are a subset of a larger survey study which also includes the practice patterns of plastic surgeons as well as oral and maxillofacial surgeons.

Objective: Determine the current practice patterns of antibiotic use in the management of facial fractures by other members of the AAFPRS.

Room 5 - Reconstructive (Chenier)

The Learning Curve in Head and Neck Microvascular Surgery after Fellowship

Steven B. Cannady, MD; Tamer Ghanem, MD; Robert Lindau, MD; Naomi Fei, MS, and Mark K. Wax, MD

Core Competencies: Patient Care

Level of Evidence: Outcomes Research

Method: A retrospective review of first 100 microvascular cases versus after first 100 cases, comparing type of free flap used, numbers of regional flaps used, flap failure, complications, and patient deaths between first and second hundred cases performed. All comparisons were done using JMP 7.0 statistical software and a Pearson test or Fisher's exact test, respectively, for multi-surgeon and two surgeon data points.

Results: Use of regional flaps did not vary in the first 100 cohort versus subsequent time period (P=0.05). Eleven flaps were aborted in the first 100 flaps versus four in subsequent cases (p=0.216). Operating room take backs for any indication occurred in 15.5% of cases in the first cohort versus 16.8% in the second (p=0.72). Complete flap failure occurred in 18 of the first cohort (7.8%) versus 9 (5.2%) of the second cohort (P=0.31). Vessel specific take backs occurred in 57.6% and 50% of overall take backs for cohort one and two (P=0.55). Death occurred equally rarely in both cohorts (p=0.05). Individual surgeon comparison between their first and second cohorts revealed similar results as the combined analysis with no significant difference in early versus late cases (p=0.05). Comparison between surgeons, showed no difference in results for the parameters tested (p<0.05).

Conclusions: Given all flaps were done by a single surgeon working immediately out of fellowship training, and in most cases, the absence of a senior surgeon in a mentoring role, this series indicates the adequacy of an AAFPRS fellowship as preparation for a successful microvascular career. Results compare favorably with national success rates, for these surgeons, from the same fellowship training, directly out of training.

Abstract Body: Objectives: To review a multiple surgeon experience with first versus after first hundred cases in microvascular reconstruction immediately following AFPRS accredited fellowship training. To critically appraise whether fellowship had adequately prepared the surgeons or whether a ‘learning’ curve was experienced in early cases as operationally defined by aborted free flaps, flap failure, complications, vessel-specific flap complications, and patient death. Methods: A retrospective review of first 100 microvascular cases versus after first 100 cases, comparing type of free flap used, numbers of regional flaps used, flap failure, complications, and patient deaths between first and second hundred cases performed. All comparisons were done using JMP 7.0 statistical software and a Pearson test or Fisher's exact test, respectively, for multi-surgeon and two surgeon data points. Results: Use of regional flaps did not vary in the first 100 cohort versus subsequent time period (P=0.05). Eleven flaps were aborted in the first 100 flaps versus four in subsequent cases (p=0.216). Operating room take backs for any indication occurred in 15.5% of cases in the first cohort versus 16.8% in the second (p=0.72). Complete flap failure occurred in 18 of the first cohort (7.8%) versus 9 (5.2%) of the second cohort (P=0.31). Vessel specific take backs occurred in 57.6% and 50% of overall take backs for cohort one and two (P=0.55). Death occurred equally rarely in both cohorts (p=0.05). Individual surgeon comparison between their first and second cohorts revealed similar results as the combined analysis with no significant difference in early versus late cases (p=0.05). Comparison between surgeons, showed no difference in results for the parameters tested (p<0.05).

Conclusions: Given all flaps were done by a single surgeon working immediately out of fellowship training, and in most cases, the absence of a senior surgeon in a mentoring role, this series indicates the adequacy of an AAFPRS fellowship as preparation for a successful microvascular career. Results compare favorably with national success rates, for these surgeons, from the same fellowship training, directly out of training.

Objective: 1. Assess the preparedness of recent graduates from an AAFPRS accredited microvascular fellowship for their practice environment; 2. Compare and contrast first 100 flap cases to subsequent cases for surgeons in this series.
Endoscope Assisted Treatment of Subcondylar Fractures Using a Transoral Approach
Todd M. Brickman MD; PhD, FACS, D’Antoni Dennis, MD; and Ryan Dornbier
Core Competencies: Patient Care
Level of Evidence: Case Series
Method: A four year retrospective review of endoscopic repair of subcondylar mandible fractures utilizing a purely transoral approach identified 26 patients who met the criteria of a subcondylar mandible fracture with condylar dislocation and/or loss of ramus height. A purely transoral approach was utilized with a transoral endoscope carrying a 30 degree endoscope for visualization of reduction and fixation. Fixation of titanium plates and screws was accomplished utilizing right angle drills and screwdrivers and no percutaneous trocars. All patients received 7 days of post-operative antibiotics and advanced their diet as tolerated. Patient follow-up was at 1-2, 4-6, and 12-24 weeks and utilized a self-directed regimen of jaw physiotherapy with tongue depressors and stretching exercises.
Results: All cases were adequately reduced and all but one was rigidly fixated (proximal bone segment was too small to accept a plate). No cases were converted to an open technique with only one case requiring post-operative maxillo-mandibulat fixation (same patient that was unable to be rigidly fixated due to small proximal segment). Adequate functional results were achieved in all patients with intra-incisal opening greater than 38 mm at six weeks post-op. No secondary revision procedures nor orthodontia were needed. There have been no post operative infections nor any necrosis of the condylar heads reported. Two patients had a 2 mm open bite deformity that resolved by the second post-operative visit. Conclusion: A purely transoral approach can provide access for adequate visualization to accomplish proper reduction and fixation with acceptable results.
Abstract Body: Objective: 1. Understand the technique of a purely transoral endoscopic approach to mandible subcondylar fractures. 2. Appreciate the outcomes and side effect profile of the transoral approach. Methods- A four year retrospective review of endoscopic repair of subcondylar mandible fractures utilizing a purely transoral approach identified 26 patients who met the criteria of a subcondylar mandible fracture with condylar dislocation and/or loss of ramus height. A purely transoral approach was utilized with an optical dissector carrying a 30 degree endoscope for visualization of reduction and fixation. Fixation of titanium plates and screws was accomplished utilizing right angle drills and screwdrivers and no percutaneous trocars. All patients received 7 days of post-operative antibiotics and advanced their diet as tolerated. Patient follow-up was at 1-2, 4-6, and 12-24 weeks and utilized a self-directed regimen of jaw physiotherapy with tongue depressors and stretching exercises. Results- All cases were adequately reduced and all but one was rigidly fixated (proximal bone segment was too small to accept a plate). No cases were converted to an open technique with only one case requiring post-operative maxillo-mandibulat fixation (same patient that was unable to be rigidly fixated due to small proximal segment). Adequate functional results were achieved in all patients with intra-incisal opening greater than 38 mm at six weeks post-op. No secondary revision procedures nor orthodontia were needed. There have been no post operative infections nor any necrosis of the condylar heads reported. There was one case of bleeding from the massteric artery that was controlled with an endoscopic clip applier and this patient also experienced a mild facial nerve paresis that resolved at the seven week po-op mark. Two patients had a 2 mm open bite deformity that resolved by the second post-operative visit. Conclusion- A purely transoral approach can provide access for adequate visualization to accomplish proper reduction and fixation with acceptable results.
Ultrathin Silicon Sheet in the Management of Post-traumatic Temporo-mandibular Joint Ankylosis in Children- A Good Alternative to Conventional Techniques
Ankur Bhatnagar, MD
Core Competencies: Patient Care
Level of Evidence: Case Series
Method: 1. All patients underwent interpositional arthroplasty using a pre-auricular incision. 2. Post surgery all children were subjective to intensive physiotherapy using a special custom made acrylic jaw mobilizer.
Results: 1. All patients had no recurrence during the follow-up period. All patient had at least 2 cm mouth opening 3. All children had excellent compliance with dynamic custom made jaw mobilizer making post operative physiotherapy easy and manageable.
Conclusions: Reconstruction of articular disc, preserving mandibular height and active physiotherapy is cornerstone for successful treatment. Ultrathin silicone sheet interposition arthroplasty is a good treatment option for recurrent and complicated cases in children. Minimal loss of mandibular height and permanent reconstruction of articular disc not only prevents further facial deformity but also reduces recurrence. Dynamic jaw exerciser allows painless active physiotherapy.
Abstract Body: TMJ Ankylosis is a serious and disabling condition especially in children that may cause problems in mastication, digestion, speech, appearance, mandibular growth and oral hygiene, invariably resulting in physical and psychological disability. No single method has produced uniformly successful results. Post operative physiotherapy has been difficult to achieve in children. Methods: We are describing a new technique of using ultrathin silicon sheet for management of recurrent post-traumatic TMJ ankylosis in children followed by intensive physiotherapy using custom made dynamic jaw exerciser. 10 children aged 6 to 15 years with unilateral post traumatic or congenital ankylosis were followed up for minimum of one year after surgery. Result: The pre-operative mouth opening varied from 2mm to 10 mm. The intra-operative mouth opening achieved ranged 3cms to 4cms. There was no extrusion of the implant in immediate and follow-up period in any of our patients. There was no recurrence during the follow-up period ranging from 1 year to 2 years.Conclusions: Reconstruction of articular disc, preserving mandibular height and active physiotherapy is cornerstone for successful treatment. Ultrathin silicone sheet interposition arthroplasty is a good treatment option for recurrent and complicated cases in children. Minimal loss of mandibular height and permanent reconstruction of articular disc not only prevents further facial deformity but also reduces recurrence. Dynamic jaw exerciser allows painless active physiotherapy.
FREE PAPER ABSTRACTS

Systematic Review of Free Flap Options for Mandibular Reconstruction and a Preliminary Quality of Life Comparison

Sami P. Moubayed, MD; Benedicte L’heureux-Lebeau, MD; Apostolos Christopoulos, MD; MSc; John S. Sampalis, PhD; Alain M. Danino, MD, PhD; Eric Bissada, MD; DMD; and Tareck Ayad, MD

Core Competencies: (Medical Knowledge, Patient Care)

Level of Evidence: Outcomes Research

Method: A systematic review of a public MEDLINE database (PubMed) using article titles was conducted. Articles describing patients with osteocutaneous free flap mandibular reconstruction were identified and analyzed. Then, 13 patients who underwent mandibular reconstruction at our hospital center were classified into one of the 3 groups: 1) Radial-forearm free-flap (RFFF) (n=3); 2) Fibula free-flap (FFF) (n=6); 3) Subscapular system free-flap (SSFF) (n=4). They all completed three quality of life (QOL) questionnaires: EORTC QLQ-C30, EORTC QLQ-H&N35, and HADS.

Results: We identified 60 articles. When pooling patient data together, the most frequently used flaps in terms of patient count are the FFF (n=982), RFFF (n=201), iliac crest (n=113), SSFF (n=50), and ribs/serratus (n=7). We systematically review indications, advantages, and disadvantages of each flap. In our local patient population, patients with FFF reconstruction showed a clinically significant trend for better results on the QLQ-C30 and QLQ-H&N35 questionnaire, although this did not reach statistical significance. Patients from the SSFF group were more depressed than other groups (p=0.025). However, patients in our FFF group were significantly younger than the patients in the other groups (53.7 years vs. 63.7 years, p=0.025), and all patients in the SSFF group had large through-and-through defects, in contrast with the other groups. Conclusion: The most frequently used flap for mandibular reconstruction is FFF in the literature. However, QOL data to compare these flaps is lacking in the literature, and homogeneous populations should be used in order to reach significant conclusions.

Abstract Body: Objectives: The aim of this study is to systematically review the publication trends in osteocutaneous free flap reconstruction of mandibular defects, and to evaluate the different free flap options at our institution in terms of quality of life (QOL), depression, and anxiety. Materials and methods: A systematic review of a public MEDLINE database (PubMed) using article titles was conducted. Articles describing patients with osteocutaneous free flap mandibular reconstruction were identified and analyzed. Then, 13 patients who underwent mandibular reconstruction at our hospital center were classified into one of the 3 groups: 1) Radial-forearm free-flap (RFFF) (n=3); 2) Fibula free-flap (FFF) (n=6); 3) Subscapular system free-flap (SSFF) (n=4). They all completed three QOL questionnaires: EORTC QLQ-C30, EORTC QLQ-H&N35, and HADS.

Results: We identified 60 articles. When pooling patient data together, the most frequently used flaps in terms of patient count are the FFF (n=982), RFFF (n=201), iliac crest (n=113), SSFF (n=50), and ribs/serratus (n=7). We systematically review indications, advantages, and disadvantages of each flap. In our local patient population, patients with FFF reconstruction showed a clinically significant trend for better results on the QLQ-C30 and QLQ-H&N35 questionnaire, although this did not reach statistical significance. Patients from the SSFF group were more depressed than other patients (p=0.031). However, patients in our FFF group were significantly younger than the patients in the other groups (53.7 years vs. 63.7 years, p=0.025), and all patients in the SSFF group had large through-and-through defects, in contrast with the other groups. Conclusion: The most frequently used flap for mandibular reconstruction is FFF in the literature. However, QOL data to compare these flaps is lacking in the literature, and homogeneous populations should be used in order to reach significant conclusions.

Objective: discuss the different options published in the literature for mandibular reconstruction in terms of frequency of use, advantages, and disadvantages and explain the quality of life, anxiety, and depression results of different osteocutaneous free flaps for mandibular reconstruction

Systematic Review of Outcome Measure Reporting after Microvascular Head and Neck Reconstruction of the Oral Cavity and Oropharynx

Eric Lamarre, MD; Steven Cannady, MD; Micheal Fritz, MD; Daniel Alam, MD; and Mark Wax, MD

Core Competencies: Patient Care

Level of Evidence: Systematic Review of case-control studies

Method: PubMed and Cochrane databases were searched for 1992-2002 by two independent searchers with search items ‘oral cavity functional outcomes free flap’, ‘oropharyngeal functional outcomes free flap’, ‘oral cavity swallowing free flap’, oropharynx swallowing free flap’, ‘oral cavity speech free flap’, ‘oropharynx speech free flap’. Studies with less than 20 patients, non-flap specific outcomes, or non-distinguishable outcome measures were excluded.

Results: Initial searches yielded 358 studies; after abstract review, a total of 112 studies remained for review. Two reviewers excluded 41 papers based on criteria set in methods. Outcome measures were recorded in the remaining 71 papers for the following parameters: Upfront vs salvage vs both (35.3% upfront, 0% salvage alone), oropharynx vs oral cavity vs both, fiberoptic endoscopic evaluation of swallowing (6.1%), modified barium swallow (38%), percutaneous gastrostomy and tracheostomy dependence (52% and 36.7%), aspiration (44.9%), subjective eating assessment (42%), food consistency ability (46%), and survey (48%) (and type (UWQOL 27.3%, All others 0%)).

Conclusions: Heterogeneity in outcome reporting is prevalent in free flap literature. These results document the descriptive outcome measures in recent literature. Using these data as a guide, the authors recommend forming consensus in methods of reporting outcome of function using validated instruments.

Abstract Body: Introduction: Little data exists to predict the functional outcomes of patients undergoing ablative head and neck surgery (HNS) of the oral cavity or oropharynx followed by free tissue reconstruction. As methods of measuring success continue to develop, it is incumbent upon head and neck surgeons to ensure use of multifaceted measures of functional outcomes in HNS to accurately compare across treatment modalities, surgical techniques, and reconstructive methods. Methods: PubMed and Cochrane databases were searched for 1992-2002 by two independent searchers with search items ‘oral cavity functional outcomes free flap’, ‘oropharyngeal functional outcomes free flap’, ‘oral cavity swallowing free flap’, oropharynx swallowing free flap’, ‘oral cavity speech free flap’, ‘oropharynx speech free flap’. Studies with less than 20 patients, non-flap specific outcomes, or non-distinguishable outcome measures were excluded. Results: Initial searches yielded 358 studies; after abstract review, a total of 112
Increased Survival of Human Adipose Derived Stem Cells in the Presence of BMP-2
Brian Lawton, MD; Joy Obokhare, MD; Matthew Clavenna, MD; and Timothy Lian, MD, FACS
Core Competencies: Medical Knowledge
Level of Evidence: Outcomes Research
Method: Human adipose tissue was collected in the form of liposuaspirated fat waste. Stem cells were isolated according to protocol and the presence of stem cells was confirmed using flow cytometry. Following the incubation period, cells were then incubated with BMP-2 at 0.01 ng/mL, 0.1 ng/mL, and 1 ng/mL for three days.
Results: Optical density and cell counts indicated increased survival of ASCs when compared to controls in those samples containing low concentrations of BMP-2. The greatest increase was associated with 0.01 ng/mL and a decreased survival was noted in the 1 ng/mL group.
Conclusions: Low concentrations of BMP-2 (0.01 ng/mL) are associated with increased survival of human ASCs.

Formation of the Inverted-V Deformity: A Finite Element Model Simulation
Tjosen Tjoa, MD; Ryan P. Leary, MD; Cyrus T. Manuel, BS; Dmitriy E. Protsenko, PhD; and Brian JF Wong, MD
Core Competencies: (Medical Knowledge, Practice-based Learning and Improvement)
Level of Evidence: Expert Opinion
Method: A finite element model (FEM) using CT-derived anatomic data was implemented in COMSOL Multiphysics®. Septum, upper, and lower lateral cartilages were generated to fit the model using CAD software. Mechanical properties of skin, cartilage and bone were taken from the literature. Two structural models were created: 1) fusion or 2) separation of ULC and septum. Force vectors were created to mimic gravity (physiologic loading) and also to simulate vectors created by wound healing after separation of ULC from septum. Steady state morphology was derived and examined for evidence of structural changes equivalent to the inverted-V deformity.
Results: Gravity alone had little effect on the dorsal architecture in either case. However, when forces simulating scar contraction in the nasal mucosa were applied in addition to gravity, various changes were noted in the upper lateral cartilages, which created mid-vault collapse, ULC displacement, and shape change similar to the inverted-V deformity.
Conclusions: While it well known that mid-vault reconstruction is critical to avoiding long-term complications in rhinoplasty, this is the first experimental study that supports this hypothesis. Mechanical analysis suggests that ULC-septal articulation is essential to preventing mid-vault collapse and inverted-V deformities. FEM simulation of contractile forces acting across fused or separated dorsal cartilages provides insight with respect to the importance of reconstruction of these structures after rhinoplasty, what force vectors are critical to counteract, and how inadequate reconstruction may lead to adverse sequelae. With the constant advent of surgical techniques to address these problems, long-term outcomes are difficult, if not impossible, to predict. We believe that future iterations of this numerical model will decrease the uncertainty involved with these rhinoplasty maneuvers.
Abstract Body: The cartilaginous framework of the nasal dorsum plays an important role in both nasal aesthetics and function. In particular, the attachments of the upper lateral cartilages (ULC) to the septum allow the framework to distribute loads, maintain patency of the internal nasal valve, and preserve morphology. Contemporary surgical techniques restore these relationships to prevent inverted-V deformity and mid-vault collapse. While it is well known that restoration is essential to achieve long-term results, no case-controlled prospective clinical studies, animal experiments or quantitative modeling has been reported. The finite element method (FEM) has previously been applied to examine the changes in stress distribution within the nasal tip resulting from an externally applied force, but has not been used to study the subtle changes in framework stress distribution that accompany rhinoplasty. In this study, the FEM examines how stress is distributed and how shape change is influenced by the relationship between the ULC and septum. Our simulations are in agreement with clinical practice in that these attachments provide rigid support and prevent buckling and aesthetic deformity.
Objective: Describe how the distribution of stress along the nasal dorsum and lateral nasal wall changes as a function of how the upper lateral cartilages (ULC) are coupled to the septum; and explain how wound contraction and gravity act to create the inverted-V deformity in the absence of a rigidly reconstructed nasal framework.

Withdrawn Oral Paper “Catastrophization and Patient Satisfaction after Rhinoplasty”

The Tripod Cartilage Repositioning Procedure to Achieve Improved Tip Rotation and Nasal Function Using the Alar™ Stent Device
Stefan W. Shuaib, MD and Howard D. Stupak, MD
Core Competencies: (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)
Level of Evidence: Case Series
Method: Institutional Review Board approval was obtained for this prospective study. Patients were appropriately consented and enrolled. Pre- and Post-operative NOSE scores and photographs were taken. Photographs were analyzed for naso-labial angle with Adobe Photoshop. Pre and Post-operative NOSE scores were compared using student’s t-test. After consent to participate in this study, patients data including age, weight, and additional procedures performed was entered into a blinded database. All patients who underwent tripod repositioning including caudal septoplasty and resuspension of the ULC/LLC interaction were included in the study. Pre and Post-operative photographs and NOSE scores were obtained.
Results: Twenty-one patients completed pre- and post-operative NOSE scores after the tripod cartilage repositioning procedure. The surveys were completed an average of 3.3 months after surgery. Pre-operative NOSE scores approached the maximal 20 with a 16.3 average score. Post-operative NOSE scores approached the minimum 0 with a 2.9 average score. This is statistically significant with p<.001. Mean preoperative naso-labial angles were calculated and compared to postoperative naso-labial angle calculations as well., showing a trend toward increase in the naso-labial angle.
Conclusions: The tripod cartilage repositioning and suspension technique described can improve the functionality of the nasal valves while also providing for an aesthetically improved nasal tip position.
Abstract Body: We utilize a simple approach to tripod cartilage repositioning to improve nasal function as well as aesthetics without changing its intrinsic structure. The nasal tripod/pedestal concept is explained in detail specifically on the interaction of the tripod with its supportive pedestal and surrounding structures. Our technique involves rotating the nasal tripod not by strengthening or weakening the actual cartilage, but by altering its interaction with the underlying septum and upper lateral cartilage pedestal. First, for the lateral limbs of the tripod, we endonasally transpose the lateral crura of the alar cartilage into increased overlap with its upper lateral cartilage to achieve tip rotation after release of the scroll and mucosa. For the medial limb of the tripod, we used the “tongue in groove” procedure described by Kridel to re-establish the septum to the medial crura. After splinting using a support device (Alar™ Device), the cartilages heal into their newly overlapped and supported position thus rotating the nasal tripod and supporting the internal and external nasal valve. Twenty one patients were enrolled in this study. Pre- and Post-operative NOSE scores and photographs were taken. Photographs were analyzed for naso-labial angle with Adobe Photoshop. NOSE scores were compared using student’s t-test. All patients underwent tripod repositioning including caudal septoplasty and resuspension of the
Objective: At the conclusion of this activity, the participant should be able to utilize a simple approach to tripod cartilage repositioning to improve nasal function as well as aesthetics without changing its intrinsic structure. The nasal tripod/pedestal concept is explained in detail specifically on the interaction of the tripod with its supportive pedestal and surrounding structures. Our technique involves rotating the nasal tripod not by strengthening or weakening the actual cartilage, but by altering its interaction with the underlying septum and upper lateral cartilage pedestal. First, for the lateral limbs of the tripod, we endonasally transpose the lateral crura of the alar cartilage into increased overlap with its upper lateral cartilage to achieve tip rotation after release of the scroll and mucosa. For the medial limb of the tripod, we used the “tongue in groove” procedure described by Kridel to re-establish the septum to the medial crura. After splitting using a support device (Alar ™Device), the cartilages heal into their newly overlapped and supported position thus rotating the nasal tripod and supporting the internal and external nasal valve.

Nasal Osteotomies: A Cadaveric Study of Fracture Lines
Nathalie Gabra, Akram Rahal, MD; and Christian Ahmarani

Core Competencies: (Patient Care, Practice-based Learning and Improvement)

Level of Evidence: Outcomes Research

Method: Twenty cadavers were divided in 2 groups. Group A had a PM combined with a LLH in one hemi-nose (A1) and a HLH alone on the other hemi-nose (A2). Group B had a PM combined with a LL osteotomy followed by T osteotomy on one hemi-nose (A1). One the other hemi-nose, we performed a PM combined with a LL osteotomy (A2). Finally we evaluated the mobility of the central segment following digital pressure alone (n=20), following a vertical transverse osteotomy (n=4) and following a lateral transverse osteotomy (n=10).

Results: The A2 group had more unstable and greenstick fractures than the A1 group (p=0.0004). The B1 group had more reliable and stable fractures than the B2 group (p=0.0498). Without a T osteotomy a LLH osteotomy tends to deviate in a low-to-high pattern. Digital manipulation alone is not enough to mobilize the central segment. The segment was mobile after both lateral and vertical transverse osteotomies. Conclusion: Following this study we suggest (1) The use of a straight unguarded osteotome instead of a curved guarded osteotome to perform a LLH osteotomy; (2) Applying the digital pressure at the level of the nasal canthus, (3) Performing a PM osteotomy when a HLH osteotomy is needed (4) Performing a T osteotomy before a LL osteotomy when combined with PM osteotomy (5) That the ideal technique to manipulate the central segment is with a bilateral lateral transverse osteotomy.

Objective: 1. To evaluate the necessity of a para-medial (PM) osteotomy when performing a High-Low-High (HLH) osteotomy; 2. To discuss the fracture pattern of a low-to-low (LL) osteotomy when combined with a para-medial osteotomy in the presence and in the absence of a transverse (T) osteotomy.

Microbiology and Antibiotic Prophylaxis in Rhinoplasty: A Review of 363 Consecutive Cases
Grace Lee Peng, MD; Donald B. Yoo, MD; Paul S. Nassif, MD; Babak Azizzadeh, MD

Core Competencies: (Medical Knowledge, Patient Care, Practice-based Learning and Improvement, Systems-based Practice)

Level of Evidence: (Case Series, Outcomes Research)

Method: A retrospective review of 363 consecutive cases of adult patients who underwent septorhinoplasty was performed. Preoperative nasal swabs were taken on all patients to establish endogenous flora, and patients colonized with pathogenic bacteria treated with culture-directed antibiotics. Patient charts were reviewed for co-morbidities, peri-operative infections, and antibiotic treatments.

Results: Our study included 363 patients, 279 (76.9%) females and 84 (23.1%) males with an average age of 35.9 years (age range 17-70 years). One-hundred and seventy-four (48%) patients underwent primary rhinoplasty, and 189 (52%) underwent revision rhinoplasty. On preoperative nasal culture, 78.2% of patients had normal flora, 10.7% had S. aureus and 0.28% had MRSA. In 7.4% of patients, fecal coliforms including E. coli, enterobacter, and citrobacter were found. Patients with adult acne were found to have an increased incidence of colonization with fecal coliforms (43.8%, p < 0.01). Age, gender, the use of oral contraceptives or the presence of allergies did not significantly change the nasal flora nor the postoperative infection rate. The overall infection rate was 3.0% (11 patients).

Conclusions: The results of this study suggest that risk factors...
Men and young women (<19) were more likely to receive payment likely to seek legal recourse were females over 55, but were not complications more often resulted in paid claims. The patients most delineate between functional and cosmetic complaints. Although rhinoplasty litigation is rare, the average indemnity is $300 thousand. Patients most often seek damages for displeasure plaintiffs seeking legal recourse.

Abstract Body: Objectives: The aim of this study was to describe the microbial flora of patients undergoing septorhinoplasty, and to evaluate the role of pre-operative and post-operative antibiotic prophylaxis. Methods: A retrospective review of 363 consecutive cases of adult patients who underwent septorhinoplasty was performed. Preoperative nasal swabs were taken on all patients to establish endogenous flora, and patients colonized with pathogenic bacteria treated with culture-directed antibiotics. Patient charts were reviewed for co-morbidities, peri-operative infections, and antibiotic treatments. Results: Our study included 363 patients, 279 (76.9%) females and 84 (23.1%) males with an average age of 35.9 years (age range 17-70 years). One-hundred and seventy-four (48%) patients underwent primary rhinoplasty, and 189 (52%) underwent revision rhinoplasty. On preoperative nasal culture, 78.2% of patients had normal flora, 10.7% had S. aureus and 0.28% had MRSA. In 7.4% of patients, fecal coliforms including E. coli, enterobacter, and citrobacter were found. Patients with adult acne were found to have an increased incidence of colonization with fecal coliforms (43.8%, p < 0.01). Age, gender, the use of oral contraceptives or the presence of allergies did not significantly change the nasal flora nor the postoperative infection rate. The overall infection rate was 3.0% (11 patients). Conclusions: The results of this study suggest that risk factors alone may not reliably predict the subset of patients in whom antibiotic prophylaxis is indicated. Knowledge of the endogenous nasal flora and the microbiology of common pathogens in patients undergoing septorhinoplasty will help to further reduce the incidence of infectious complications.

Objective: 1. Understand common bacteria seen in post rhinoplasty infections; 2. evaluate benefit of pre-operative, perioperative, and post-operative use of antibiotics both oral and topical; and 3. assess possible causes for infection after rhinoplasty.

Room 7 - Rhinoplasty (Grand E)

Rhinoplasty Litigation: Trends, Pitfalls and Financial Burden-- A 25 Year Review
Jared R. Seibert, MD and Scott B. Roofe, MD

Core Competencies: (Interpersonal and Communication Skills, Practice-based Learning and Improvement, Systems-based Practice)

Level of Evidence: Case Series

Method: We queried the WestLaw and LexisNexis legal databases for the term “rhinoplasty” and “malpractice” between the years 1986-2012. Court records were examined for cases in which rhinoplasty outcomes and complications were the central reason for plaintiffs seeking legal recourse.

Results: 99 separate cases were noted from 1986-2012. Although rhinoplasty litigation is rare, the average indemnity is more than $300 thousand. Patients most often seek damages for displeasure with outcome. The legal documentation reviewed did not usually delineate between functional and cosmetic complaints. Although patient satisfaction was more likely to result in litigation, surgical complications more often resulted in paid claims. The patients most likely to seek legal recourse were females over 55, but were not more likely to receive payment than other age groups of women. Men and young women (19) were more likely to receive payment than other groups. Individuals in the New England and Mid-Atlantic states were the most likely to pursue legal recourse. Plastic surgeons were the most likely to be sued, followed by otolaryngologists. Facial Plastic and Reconstructive Surgeons (FPRS), while less frequently sued, were the most likely to have indemnity payment when sued in addition to having a significantly larger (>10x) indemnity than other specialists.

Conclusions: FPRS are the least likely to be sued but the most likely to have high indemnity payments for lawsuits involving rhinoplasty medical malpractice. High risk groups for litigation are older (>55) female patients who live in the New England and Mid-Atlantic states and Plastic surgeons followed by Otolaryngologist. High risk for indemnity include young (<19) female and male patients and FPRS. Caution should be taken to ensure each patient is aware of possible complications and untoward outcomes.

Abstract Body: Abstract Background: Rhinoplasty is one of the most common cosmetic surgical procedures performed in United States. Despite being commonplace, it is also one of the most technically challenging procedures not only in surgical execution but also in meeting patients’ expectations. The dissatisfied patient may seek legal recourse for negative outcomes, whether real or perceived. The financial, social and psychological impact of litigation can be devastating for the surgeon(s) involved. Objective: 1. Discuss the patient demographics (age, gender, state of residence, legal complaint) that are most likely to lead to litigation with a patient who underwent rhinoplasty. 2. Discuss the patient demographics (age, gender, state of residence, legal complaint) that are most likely to result in a verdict in favor of a patient who underwent rhinoplasty. Methods: We queried the WestLaw and LexisNexis legal databases for the term “rhinoplasty” and “malpractice” between the years 1986-2012. Court records were examined for cases in which rhinoplasty outcomes and complications were the central reason for plaintiffs seeking legal recourse.

Results: 99 separate cases were noted from 1986-2012. Although rhinoplasty litigation is rare, the average indemnity is more than $300 thousand. Patients most often seek damages for displeasure with outcome. The legal documentation reviewed did not usually delineate between functional and cosmetic complaints. Although patient satisfaction was more likely to result in litigation, surgical complications more often resulted in paid claims. The patients most likely to seek legal recourse were females over 55, but were not more likely to receive payment than other age groups of women. Men and young women (19) were more likely to receive payment than other groups. Individuals in the New England and Mid-Atlantic states were the most likely to pursue legal recourse. Plastic surgeons were the most likely to be sued, followed by otolaryngologists. Facial Plastic and Reconstructive Surgeons (FPRS), while less frequently sued, were the most likely to have indemnity payment when sued in addition to having a significantly larger (>10x) indemnity than other specialists.

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Objective: Discuss the patient demographics (age, gender, state of residence, legal complaint) that are most likely to lead to litigation with a patient who underwent rhinoplasty; and discuss the patient...
FREE PAPER ABSTRACTS

demographics (age, gender, state of residence, legal complaint) that are most likely to result in a verdict in favor of a patient who underwent rhinoplasty.

The Underlying Relationship of the Upper Lateral Cartilage with the Pyriform Aperture
John R. Craig, MD, and Amar Suryadevara, MD
Core Competencies: (Medical Knowledge, Patient Care, Practice-based Learning and Improvement, Systems-based Practice)
Level of Evidence: Outcomes Research
Method: Noses of 6 fixed cadavers were dissected by open rhinoplasty to expose the entirety of the ULCs bilaterally, from the dorsal septum medially to the pyriform aperture laterally. Subperiosteal dissection was carried out along the pyriform aperture, superiorly along its entire articulation with the ULCs, and ended over the nasal bones. Still images were taken with a rigid nasal endoscope of the external relationship between the ULC and pyriform aperture, and their gross anatomic relationship was recorded for each side of the cadaveric specimens. Iris scissors and a 4-mm straight osteotome were used to excise each specimen unilaterally, consisting of the ULC, pyriform aperture, and 5-mm maxillary bone. The ULCs on each side were released from the dorsal septum and nasal bones, though were left attached to the pyriform aperture laterally. Osteotomies were then made along the frontal process of the maxilla to deliver the specimen as a continuous piece of tissue. Each specimen was labeled and sent to the pathology lab for histologic evaluation.
Results: The lateral aspect of the ULC was found to underlie the bony pyriform aperture in 100% of the cadavers dissected, similar to its constant underlying relationship with the nasal bones. The ULC articulated with the undersurface of the pyriform aperture through strong fibrous tissue, presumably decussating fibers from the ULC perichondrium and maxillary periosteum.
Conclusions: The lateral aspect of the ULC was found to underlie the bony pyriform aperture in 100% of the cadavers dissected in this study, a relationship yet to be reported in the literature. Thus far, more attention has been directed at treating the narrowed INV angle from medial ULC collapse, with less consideration of treating the narrowed lateral INV area. The lateral ULC contributes to the total INV cross-sectional area, and if collapsed, may contribute to INV dysfunction. The lateral INV should be evaluated in patients with nasal obstruction due to INV collapse, and should be considered when planning functional rhinoplasty.
Objective: Describe and illustrate the anatomic relationship of the lateral aspect of the upper lateral cartilage (ULC) at its articulation with the pyriform aperture; and discuss the potential contribution of this anatomy to internal nasal valve (INV) collapse

Development of a Severity Classification System for Subjective Nasal Obstruction
Michael J. Lipan, MD and Sam P. Most, MD
Core Competencies: (Interpersonal and Communication Skills, Medical Knowledge, Patient Care, Practice-based Learning and Improvement, Systems-based Practice)
Level of Evidence: Individual case-control study
Method: Patients’ responses on the Nasal Obstruction Symptom Evaluation (NOSE) instrument were analyzed retrospectively. Scores from patients, with or without a complaint of nasal obstruction, were used to develop a classification system after receiver operating characteristic analysis. The classification sub-divides nasal obstruction patient scores into range defined classes. All patients were seen at a University-based tertiary medical center.
Results: A score of 30 on the NOSE survey best differentiated patients with and without nasal obstruction. This threshold also provided intervals used to define the other class ranges. Patients are categorized as having mild (5-25), moderate (30-50), severe (55-75) or extreme (80-100) nasal obstruction depending on responses on the NOSE survey.
Conclusions: The NOSE scale is an important tool for gauging symptoms in patients with nasal obstruction. The proposed classification system will improve patient care by providing a framework for the severity of their symptoms and helping them understand potential treatment effects. If the classification is used in future outcomes research, it will allow physicians to better understand the study population and the impact of treatment on each severity class.
Abstract Body: Objective: To develop a classification system for nasal obstruction using a subjective validated quality of life instrument. Methods or Design: Patients’ responses on the Nasal Obstruction Symptom Evaluation (NOSE) instrument were analyzed retrospectively. Scores from patients, with or without a complaint of nasal obstruction, were used to develop a classification system after receiver operating characteristic analysis. The classification sub-divides nasal obstruction patient scores into range defined classes. All patients were seen at a University-based tertiary medical center. Results: A score of 30 on the NOSE survey best differentiated patients with and without nasal obstruction. This threshold also provided intervals used to define the other class ranges. Patients are categorized as having mild (5-25), moderate (30-50), severe (55-75) or extreme (80-100) nasal obstruction depending on responses on the NOSE survey.

Surgical Approach to Nasal Obstruction in Patients with Sleep-Disordered Breathing Using Functional Rhinoplasty and Drug-Induced Sleep Endoscopy
Amy L. Richter, MD and Krista Olson, MD
Core Competencies: (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)
Level of Evidence: Case Series
Method: We performed a retrospective chart review of over 25 patients with SDB and obstructed nasal airway secondary to septal deviation, inferior turbinate hypertrophy, and internal nasal valve collapse who presented to a facial plastics and reconstructive surgery tertiary referral center for evaluation and treatment. We present pre-operative polysomnogram findings, pre-operative photos, intra-operative drug induced sleep endoscopic findings, post-operative photos, pre-operative and post-operative continuous positive airway pressure (CPAP) compliance. We describe operative techniques of DISE combined with functional rhinoplasty including use of spreader grafts, alar batten grafts, and lateral crural strut grafts in a single procedure.
Results: The patients in this case series who underwent DISE with functional rhinoplasty demonstrated significant subjective improvement in nasal airflow, decreased CPAP settings resulting in improved CPAP tolerance and in certain patients, resolution of SDB. The DISE performed immediately prior to intubation for rhinoplasty allowed identification of oropharyngeal areas of pathology to be addressed in secondary stage surgical procedures. Conclusions: Few studies have identified the role of functional septorhinoplasty in SDB and no studies have examined the utility of DISE combined with functional rhinoplasty in a first-stage procedure for sleep apnea. Here we demonstrate that functional rhinoplasty with nasal valve reconstruction combined with sleep endoscopy not only improves nasal symptoms and CPAP tolerance, but also identifies those patients who may further benefit from oropharyngeal sleep apnea surgery.

Abstract Body: The nose has been shown to play a large role in upper airway resistance that contributes to sleep-disordered breathing. Drug-induced sleep endoscopy allows for analysis of the nose and oropharyngeal airway to identify pathologic areas of obstruction and candidates for sleep surgery. By using functional septorhinoplasty techniques, including spreader grafts, alar batten grafts, and lateral crus strut grafts, combined with drug-induced sleep endoscopy we are able to significantly improve nasal airway obstruction and sleep-disordered breathing symptoms as well as identify candidates for further oropharyngeal sleep surgery.

Objective: Describe a surgical approach to analyze and treat the obstructed nasal airway in patients with sleep-disordered breathing (SDB) using drug-induced sleep endoscopy (DISE) and functional septorhinoplasty.

Evaluation of Nasal Valve Obstruction in Functional and Functional-Aesthetic Rhinoplasty Patients
Basil Hassouneh, MD; David W. Kim, MD; and Andrea Yeung, MD
Core Competencies: Medical Knowledge
Level of Evidence: Cohort Study
Method: This was a prospective multi-center cohort study recruiting consecutive patients for participation. All patients had significant nasal valve obstruction and accepted functional or functional-aesthetic rhinoplasty. Discuss the impact of patient’s age on nasal valve obstruction. Methods: This was a prospective multi-center cohort study recruiting consecutive patients for participation. All patients had significant nasal valve obstruction and accepted functional or functional-aesthetic rhinoplasty to improve their symptoms. Patients had clinical nasal examination and administration of NOSE scale at baseline (phase one). Subsequently, NOSE scale was administered at 3, 6 and 12 months postoperative (phase two). Results: There were 94 candidate patients identified and participated in baseline data collection. Of those, 79 patients also participated in phase two of the study for postoperative NOSE scores assessment. Modified cottle maneuver showed moderate and consistent correlation with patient’s NOSE scores (rho = 0.38, p < 0.005), and lateral wall collapse showed only weak correlation (rho = 0.25, p < 0.05). Internal nasal valve angle, external nasal valve collapse and supra-alar/middle-vault pinching did not show significant correlation with patient symptoms. Patients with higher baseline NOSE scores showed larger postoperative improvement in their symptoms (rho = 0.72, p < 0.0005). This relationship was robust and linear over the range of baseline NOSE scores. Overall, older patients demonstrating worse nasal valve obstruction findings (lateral wall collapse and modified cottle maneuver) and NOSE scores compared with younger patients, p < 0.05. Conclusions: Modified cottle maneuver and lateral wall collapse are useful clinical examination tools to diagnose and evaluate the degree of nasal valve obstruction. Nonetheless, the overall correlation between examination findings and symptoms is modest. Baseline NOSE scores are strong indicator for the degree of postoperative improvement. Furthermore, older patients presents with higher nasal valve obstruction findings and symptoms, which may be related to the cartilage and soft tissue changes associated with aging. These findings are important when considering patients for functional or functional-aesthetic rhinoplasty.

Abstract Body: Introduction and Objectives: Nasal valve obstruction is a well-recognized cause of nasal airway compromise. Rhinoplasty can offer significant improvement in the nasal obstruction symptoms. This study evaluated the correlation between physician’s examination of nasal valve obstruction and patient’s symptoms assess with Nasal Obstruction Symptom Evaluation (NOSE) scale. The study also examined potential clinical indicators of postoperative improvement, and the effect of patient’s age on nasal valve obstruction. Methods: This was a prospective multi-center cohort study recruiting consecutive patients for participation. All patients had significant nasal valve obstruction and accepted functional or functional-aesthetic rhinoplasty to improve their symptoms. Patients had clinical nasal examination and administration of NOSE scale at baseline (phase one). Subsequently, NOSE scale was administered at 3, 6 and 12 months postoperative (phase two). Results: There were 94 candidate patients identified and participated in baseline data collection. Of those, 79 patients also participated in phase two of the study for postoperative NOSE scores assessment. Modified cottle maneuver showed moderate and consistent correlation with patient’s NOSE scores (rho = 0.38, p < 0.005), and lateral wall collapse showed only weak correlation (rho = 0.25, p < 0.05). Internal nasal valve angle, external nasal valve collapse and supra-alar/middle-vault pinching did not show significant correlation with patient symptoms. Patients with higher baseline NOSE scores showed larger postoperative improvement in their symptoms (rho = 0.72, p < 0.0005). This relationship was robust and linear over the range of baseline NOSE scores. Overall, older patients demonstrating worse nasal valve obstruction findings (lateral wall collapse and modified cottle maneuver) and NOSE scores compared with younger patients, p < 0.05. Conclusions: Modified cottle maneuver and lateral wall collapse are useful clinical examination tools to diagnose and evaluate the degree of nasal valve obstruction. Nonetheless, the overall correlation between examination findings and symptoms is modest. Baseline NOSE scores are strong indicator for the degree of postoperative improvement. Furthermore, older patients presents with higher nasal valve obstruction findings and symptoms, which may be related to the cartilage and soft tissue changes associated with aging. These findings are important when considering patients for functional or functional-aesthetic rhinoplasty.
The Surgical Hairline Advancement/Forehead Shortening Procedure—An Effective One-Stage Technique for Lowering the Overly High Female Hairline

Jeffrey Epstein, MD, FACS

Core Competencies: (Patient Care, Practice-based Learning and Improvement)

Level of Evidence: Case Series

Method: Large case volume presentation

Results: The author has performed over 600 procedures for advancing the overly high female hairline, the majority with hair transplantation techniques. The alternative technique, the surgical hairline advancement technique, has been performed on over 570 patients over the past eight years, with an average of 4cm of hairline lowering achieved, and one of the highest rates of patient satisfaction of any group of surgical patients, due to the low incidence of complications and the virtually immediate results achieved.

Conclusions: The Surgical Hairline Advancement technique is a valuable adjunct for any surgeon who treats the aging face. Appreciation of the importance of forehead height and appropriate hairline position in women, and proficiency in performing browlifting surgery are the main prerequisites for effectively performing this procedure, which when performed properly has a very low rate of complications.

Abstract Body: Within the contexts of one of the country's busiest hair transplant practice, the presenter has surgically treated over 500 female patients seeking to have an overly high hairline lowered. The most common technique is through the use of hair grafting, where as many as 4000 grafts each containing from one to two hairs are transplanted in a single procedure, each graft one at a time—a technique that takes not only specialized expertise and a trained team of assistants, but also requires close to a full year to realize the final results. The alternative technique, for the appropriate patient, is the surgical hairline advancement/forehead shortening procedure, which in a single 90 minute procedure can achieve very impressive results virtually immediately. This is a technique that any surgeon with experience in performing browlifting can effectively and safely perform, not only helping to avoid the usually unwanted side effect of hairline elevation with many types of browlifting procedures, but also to create better facial harmony in women.

Objective: Determine the candidacy for the female patient concerned with the high hairline, seeking to have the forehead shortened. Understand the key steps to the technique of the surgical hairline advancement procedure. Be able to perform this procedure, with an understanding of how to minimize the risk of complications while achieving the greatest amount of hairline advancement. Recognize how to lower the overly high hairline in patients seeking brow lifting.

Endoscopic Facial Rejuvenation

Thomas Romo III, MD

Core Competencies: (Medical Knowledge, Patient Care)

Level of Evidence: Case Series

Abstract Body: Summary: Management of the aging face is a complex and multifaceted process. Treatment protocols are established on specific diagnosis. These include age-related changes of the facial skin presenting with dermal thinning and rhytids, subcutaneous facial changes including lipoatrophy and sarcopenia. Gravitational changes of the aging face present as soft tissue ptosis. Each of these conditions require different treatments modalities. Our preferred method of managing soft tissue ptosis of the aging upper half of the face is to utilize endoscopic surgical technique. Indications for surgery, technical aspects and long term results will be presented.

Objective: At the conclusion of this course, the participant should be able to 1. Evaluate the variable causes of the aging face. 2. Interpret the methods for endoscopic facial rejuvenation surgery. 3. Recognize the benefits and limitations of this management technique.

The Role of the Facial Plastic Surgeon in Treating Complications of Nonsurgical Facial Rejuvenation

Ameet Grewal, MD; Samaneh Ashktorab, MD; and Steven P. Davison, MD

Core Competencies: (Interpersonal and Communication Skills, Medical Knowledge, Patient Care, Systems-based Practice)

Level of Evidence: Case Series

Method: Literature review

Conclusions: Nonsurgical facial rejuvenation is a rapidly expanding market. Healthcare providers who are unfamiliar with facial anatomy and proper injection technique are often performing these injections. Facial plastic surgeons must be aware of the resulting serious complications and know how to treat them.

Abstract Body: Nonsurgical facial rejuvenation fastest growing office based procedure with over 11.6 million procedures done yearly in the United States (Nettar, 2012). Health care providers of all levels of training inject soft tissue fillers and neuromodulators routinely. Complications of injectables range from local site reactions to more serious complications such as angioedema, skin necrosis or permanent blindness. Patients who suffer these complications are often referred to facial plastic surgeons. It is often the role of the facial plastic surgeon to care for the medical, emotional and cosmetic effects of these complications. Safety profiles for fillers are considered to be low-risk, but serious events occur. Patients should be informed of possible permanent side effects. Knowledge of the facial anatomy and the appropriate plane of filler placement is necessary for safe injections. Errors in judgment and technique are preventable. Proper training, qualification and physician oversight are recommended and will be discussed.

Objective: At the conclusion of this activity, the participants should be able to discuss the most common adverse reactions to soft tissue fillers and identify the most severe complications; and evaluate patients with complications after nonsurgical facial rejuvenation in order to best treat their medical concerns.
Hyperbaric Oxygen Therapy for Treatment of Facial Skin Necrosis following Soft Tissue Filler Injection
Ameet Grewal, MD; Samanesh Ashktorab, MD; Richard Davila, BS, Michael J. Reilly, MD, and Kenneth Newkirk, MD
Core Competencies: (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)
Level of Evidence: Case Series
Method: Case report and literature review
Results: Our patient experienced resolution of nasolabial skin necrosis following a series of hyperbaric oxygen treatments
Conclusions: Hyperbaric oxygen therapy can be used to treat skin necrosis after intravascular soft tissue filler injection.

Abstract Body: We present the first case using hyperbaric oxygen therapy to successfully treat facial skin necrosis following subcutaneous injection of calcium hydroxyapatite into the nasolabial folds. Injectable filler fillers are a commonplace office procedure with an overall very favorable safety profile. However, reports of presumed intravascular injection and subsequent facial skin necrosis have been described and there is sparse literature to aid in the management of this dreaded complication. Existing data and treatment protocols will be reviewed, in conjunction with a description of our own experience.

Objective: At the conclusion of this activity, the participant should be able to: 1. Assess the utility of dermis fat grafting to the superior sulcus 2. Compare and contrast alternative procedures to dermis fat grafting for senescent changes of the orbital tissues, specifically those comprising the superior sulcus.

Abstract Body: Aging changes of the superior sulcus require unique considerations for rejuvenation with volume augmentation. The proximity of the superior sulcus to the globe and orbital structures, presents challenges that are not replicated elsewhere in the face. Muscles of eye and lid movement, nerves, superior ophthalmic vein, and lacrimal gland pass in close proximity or directly within the superior sulcus. Disruption of these structures may result in a spectrum of complications from minor cosmetic alterations to vision threatening sequelae. This paper describes a method of dermis fat grafting for senescent changes of the orbital tissues, specifically those comprising the superior sulcus.

Conclusions: The described method of dermis fat grafting may be utilized individually or added to other facial rejuvenation procedures to improve periorbital volume and cosmesis. Sulcus depth was improved in all patients with excellent symmetry in both unilateral and bilateral cases. The procedure described is effective in volume augmentation of the superior sulcus, has a high safety profile in a surgical area with numerous potential complications, and is reliable for producing symmetrical results in unilateral and bilateral cases.

Abstract Body: Orificialis/SMAS wedge resection for improved midface rejuvenation
Craig Czyz, DO and T. William Evans, MD
Core Competencies: (Medical Knowledge, Patient Care)
Level of Evidence: Case Series
Method: A surgical technique that consists of an extended sub SMAS facelift that includes a suborbicularis oculi muscle and suborbicularis oculi fat (SOOF) dissection to interrupt the infraorbital osteocutaneous ligaments. A wedge excision of the orbital portion of the orbicularis oculi muscle and underlying SOOF/SMAS is then formed allowing for passive mobilization and tissue translocation once the SMAS flap is secured.

Results: The combination of removing a wedge of the orbital portion of the orbicularis oculi muscle and the subaponeurotic/deep fascia interruption of the infraorbital osteocutaneous ligaments results in significant rejuvenation of the lower eyelid, lower eyelid cheek continuum (palpebral malar groove) and the melononalabial groove (midface).

Conclusions: The described surgical method negates the need for subcutaneous blepharoplasty for skin removal when combined with a facelift. Rarely does additional fat from the lower eyelid require removal. In the rare case of persistent skin laxity of the lower eyelid, laser skin resurfacing can be utilized. In our experience, removal of a wedge of the orbital portion of the orbicularis oculi muscle does not interfere with the function of the orbicularis oculi muscle.

Abstract Body: Facelifting techniques correct the aesthetic appearance of the midface in varying degrees. An adjunctive technique can be performed with a superficial muscular aponeurotic system (SMAS) facelift that will rejuvenate the lower eyelid, lower eyelid/cheek continuum, and midface without a subcutaneous or tranconjunctival incision.

Objective: At the completion of this activity the participant should be able to: 1. compare the outcomes of face lift procedures with and without orbicularis resection; 2. discuss the benefits of orbicularis/SMAS resection with face lift; and 3. perform orbicularis/SMAS wedge resection.

Periorbital Volumetric Rejuvenation Utilizing Dermis Fat Graft
Craig Czyz, DO and Jill Foster, MD
Core Competencies: (Medical Knowledge, Patient Care)
Level of Evidence: Outcomes Research
Method: Patients with volumetric loss characterized as a sunken superior sulcus or hollow superior sulcus underwent aesthetic alteration of the superior sulcus with volume addition via a dermis fat graft.

Results: There were no surgical or clinical complications resulting from the procedure. All patients achieved symmetric and aesthetic improvement.

Conclusions: The described method of dermis fat grafting may be utilized individually or added to other facial rejuvenation procedures to improve periorbital volume and cosmesis. Sulcus depth was improved in all patients with excellent symmetry in both unilateral and bilateral cases. The procedure described is effective in volume augmentation of the superior sulcus, has a high safety profile in a surgical area with numerous potential complications, and is reliable for producing symmetrical results in unilateral and bilateral cases.

Radiesse® for Check Augmentation: A Five-year Experience
Maher Younes, MD and Michael S. Godin, MD
Core Competencies: Medical Knowledge
Level of Evidence: Cohort Study
Method: Retrospective chart review
Results: A total of 427 patients received Radiesse® for facial rejuvenation in the past five years. 374 of these patients (87.6%) received this material for malar and/or submalar augmentation as part of their treatment. The median age of patients was 53.2 years. The average number of treatments per patient was 2.2. The duration between each treatment was 11 months. The complications encountered were rare and included bruising, asymmetry and swelling.

Conclusions: Radiesse is a reliable filler for the augmentation of the malar and/or submalar regions in the aging face.

Abstract Body: Injectable calcium hydroxylapatite (Radiesse®) is FDA-approved for the correction of facial lipoatrophy and moderate to severe facial wrinkles and folds. It is also used “off-label” to treat other areas of the face and body. The present study chronicles the use of Radiesse® for cosmetic enhancement of the cheek area for malar and submalar augmentation. We have
Trans-Oral Submandibular Gland Excision: Avoiding the Unsightly Neck Scar
Michelle Fisher, MD; Jamie Segel, MD; and Jimmy J. Brown, MD

Objective: At the end of this study, the reader should have a good overview of the use of Radiesse® in facial rejuvenation for the malar and submalar regions. In addition, the potential complications and proper methods of injection will be discussed.

Abstract Body: Introduction: Avoiding a potentially unsightly scar in the neck has been a strong driving force for patients and doctors to seek minimally invasive surgical approaches in the head and neck region. The ability of otolaryngologists to perform minimal access, remote access or cosmetic approaches to the thyroid and parotid glands have grown significantly in the last decade. This advancement has lagged behind for the removal of the submandibular glands. Learning Objectives: At the completion of this activity, the participant should be able to appreciate the advantages of a trans-oral approach and to offer this to our patients.

Method: The case of a 42 year-old male with sialadenitis is presented. The authors’ trans-oral technique of resecting the submandibular gland, and thus avoiding a neck incision, is reviewed.

Results: Removal of the submandibular gland via the trans-oral route drastically improve the cosmetic outcomes of our patients and decrease the chance for recurrent mucoceles or stone formation.

Conclusions: Improving the cosmetic outcomes of our patients with benign conditions of the submandibular gland should be a key focus of surgery. The Otolaryngologist / Facial plastics surgeon is uniquely trained to negotiate the intricate anatomy of the head and neck region. It is not unreasonable then for us to use our knowledge and expertise specific to a trans-oral approach and to offer this to our patients.

Evaluation of a Unique Side Firing 800 um Laser Fiber Operating at 1440 Um for the Treatment of Mild to Moderate Acne Scarring
Richard D. Gentile, MD; MBA

Objective: appreciate the advantages of a trans-oral submandibular gland excision over the standard neck dissection especially in patients with an increased risk for poor scar outcomes; and familiarize themselves with a proposed technique to remove the submandibular gland trans-orally and thus avoiding an unnecessary, unsightly neck scar.

Evaluation of the Effect of Injected Platelet Rich Plasma on Recovery After Ablative Fractional Photothermolysis
Haena Kim, MD and Julio F. Gallo, MD

Objective: Understand the unique attributes of the 3 dimensional laser fiber for delivering energy based subcutaneous treatments Understand the wound healing response and how neocollagenesis in the subcutaneous facial plane can improve acne scarring; and understand the usefulness of subcutaneous laser treatments in patients of color.

Evaluation of the Effect of Injected Platelet Rich Plasma on Recovery After Ablative Fractional Photothermolysis
Haena Kim, MD and Julio F. Gallo, MD

Objective: Understand the unique attributes of the 3 dimensional laser fiber for delivering energy based subcutaneous treatments Understand the wound healing response and how neocollagenesis in the subcutaneous facial plane can improve acne scarring; and understand the usefulness of subcutaneous laser treatments in patients of color.
and Intervention. Autologous PRP was harvested from each volunteer. Using the Lumenis UltraPulse fractional CO2 laser (60 mJ at 150 Hz), a 1cm2 area on each forearm. Immediately after the laser treatment, patients were randomized to receive PRP in the right or left forearm and saline in the other forearm. Pictures of each forearm were taken immediately after injection of PRP and then on a daily basis until re-epithelialization (scab formation) occurred. After re-epithelialization, pictures were taken every 2-3 days until all erythema had resolved. All pictures were graded on erythema, edema, and re-epithelialization by two blinded physicians. All subjects also completed a post-study survey on their experience of treatment side effects.

Results: We evaluated all the study subjects for post treatment erythema, edema, and re-epithelialization in sequential, daily photographs. Upon review of the initial participants we have noted the most improvement in post treatment erythema. Re-epithelialization (scab formation) occurred at a similar rate in forearms treated with PRP or saline. All patients also completed a post-treatment survey comparing erythema, edema, pruritis, and pain in their arms. Survey results indicated a majority of patients had a reduction in post treatment erythema, edema, pruritis, and discomfort.

Conclusions: Our preliminary results suggest that following CO2 fractional laser treatment with platelet rich plasma (PRP) can objectively reduce post treatment erythema. Most importantly, patients, themselves, have noticed a reduction in the common post treatment effects: erythema, edema, pruritis, and discomfort. We anticipate that PRP can be an efficacious adjunctive treatment to AFP and aid patients in hastening their return to their normal routine.

Abstract Body: Ablative fractional photothermolysis (AFP) revolutionized skin resurfacing and rejuvenation. Despite the advantages and reduced downtime of AFP, patients still seek adjuvant treatments to reduce healing time and facilitate their return to normal social and work activity. Platelet rich plasma (PRP) has been used for many applications in various surgical fields for its ability to improve wound healing, hemotastasis, and graft survival. We hypothesize that PRP will be an effective adjunctive treatment to AFP and reduce healing time and duration of side effects. IRB approval was obtained to conduct a study on 15 healthy volunteers at The Miami Institute for Age Management and Intervention. Autologous PRP was harvested from each volunteer. Using the Lumenis UltraPulse fractional CO2 laser (60 mJ at 150 Hz), a 1cm2 area on each forearm of every subject. Immediately after the laser treatment, patients were randomized to receive PRP in the right or left forearm and saline in the other forearm. Pictures of each forearm were taken immediately after injection of PRP and then on a daily basis until re-epithelialization (scab formation) occurred. After re-epithelialization, pictures were taken every 2-3 days until all erythema had resolved. All pictures were graded on erythema, edema, and re-epithelialization by two blinded physicians. All subjects also completed a post-study survey on their experience of treatment side effects. We evaluated all the study subjects for post treatment erythema, edema, and re-epithelialization in sequential, daily photographs. Upon review of the initial participants we have noted the most improvement in post treatment erythema. Re-epithelialization (scab formation) occurred at a similar rate in forearms treated with PRP or saline. All patients also completed a post-treatment survey comparing erythema, edema, pruritis, and pain in their arms. Survey results indicated a majority of patients had a reduction in post treatment erythema, edema, pruritis, overall discomfort. Our preliminary results suggest that following CO2 fractional laser treatment with platelet rich plasma (PRP) can objectively reduce post treatment erythema. Most importantly, patients, themselves, have noticed a reduction in the common post treatment effects: erythema, edema, pruritis, and discomfort. We anticipate that PRP can be an efficacious adjunctive treatment to AFP and aid patients in hastening their return to their normal routine.

Objective: At the conclusion of this study, the participant should be able to compare and contrast the effect of platelet rich plasma (PRP) and saline on recovery after treatment with ablative fractional photothermolysis (AFP).

Methotrexate-induced Cutaneous B-cell Lymphoma Masquerading as Facial Cellulitis
Celeste C. Gary, MD; and Laura Hertzler, MD
Core Competencies: (Medical Knowledge, Patient Care)
Level of Evidence: Case Series
Method: Case Report and Literature Review
Results: A 90 year old gentleman presented with central facial skin involvement of what appeared to be an extensive cellulitis of infectious etiology which was not amendable to treatment. After much investigation a link was made between his long term methotrexate use and the risk for cutaneous lymphomas.

Conclusions: Methotrexate-induced cutaneous B-cell lymphoma is an entity that should be considered in patients who present with the appearance of facial cellulitis on long term methotrexate therapy.

Abstract Body: Literature Review: Over the past 20 years, a rising trend has been noted in the incidence of lymphoma, including cutaneous forms, in patients who have rheumatoid arthritis treated with long term methotrexate. This rare but serious complication has been hypothesized to be secondary to both increased immunosuppression with genetic predisposition and increased frequency of latent infections such as EBV. While most of the reported cases site complete regression of these malignancies with cessation of methotrexate use, the diagnosis can be difficult to ascertain. Case Report: We report a case of a 90 year old gentleman who presented with central facial skin involvement of what appeared to be an extensive cellulitis of infectious etiology which was not amendable to treatment. After much investigation a link was made between his long term methotrexate use and the risk for cutaneous lymphomas. Biopsy was able to confirm this diagnosis.

Objective: To describe a case of methotrexate-induced cutaneous B-cell lymphoma presenting as facial cellulitis, stressing the importance of considering a wide differential and expediting biopsy.

Management of Frontocutaneous Fistulae Resulting from Pott’s Puffy Tumor
Robert S. Schmidt, MD; and Anita Sethna, MD
Core Competencies: (Medical Knowledge, Patient Care)
Level of Evidence: Case Series
Method: Multi-institutional case series evaluating closure of frontocutaneous fistulae using superior and inferior Burrow’s triangles and wide undermining of the skin and soft tissue of the forehead.

Results: Both patients in this series obtained excellent long-term cosmetic results without recurrence of the fistula
Conclusions: Pott's puffy tumor can be mistaken for infected sebaceous cysts. They can result in frontocutaneous fistulae if incision and drainage is attempted without addressing the underlying sinus disease. Frontocutaneous fistulae can be closed with optimal cosmetic results by creating Burrows triangles superior and inferior to the defect along with wide undermining of the skin of the forehead. Intraoperative skin expansion may be required.

Abstract Body: Pott’s puffy tumor is an uncommon complication of frontal sinusitis. It can be mistaken for an inflamed sebaceous cyst in the forehead. Simple incision and drainage can result in a fistula between the frontal sinus and the skin. We present two cases of frontocutaneous fistulae resulting from Pott’s puffy tumor, showing our technique for closing the fistula with excellent long-term results.

Objective: 1) Explain the risk factors for forming a frontocutaneous fistula 2) Explain the technique for closing a frontocutaneous fistula resulting from Pott’s puffy tumor.

A Novel System for Delivering Precisely-Targeted Electrical Stimulation to Denervated Facial Musculature
Colin R. Stoetzenzer, PhD, Garrett R. Griffin, MD; Sarah J. Novis, MD; Greg J. Gage, PhD, and Jennifer C. Kim, MD
Core Competencies: Medical Knowledge
Level of Evidence: Outcomes Research
Method: A system combining novel hardware and software configurations was developed to allow precise control over the geometry and amplitude of electrical stimulation delivered through a thin-film microelectrode array in a rodent model. This system allows automated video recording of the facial movement elicited for later analysis.

Results: The system was found to be highly efficient and user-friendly for the intended task. The software interface allows one to simply type in the amplitude (milliamps), pulse duration (milliseconds), number of pulses, and rate of pulse delivery (Hz). The hardware permits rapid selection of the number, and geometry, of dipoles that will be used to deliver the current. In our preliminary testing, 1-4 dipoles were used in 6 different configurations to stimulate whisking in a rat model using a 32-contact microelectrode array.

Conclusions: This system allows easy and precise control over the amplitude and geometry of electrical current that is delivered to rat facial musculature. It also automatically records high-quality video of the resultant facial movement for later analysis. This system represents a powerful tool allowing one to study the location of electrodes and the electrophysiological parameters that produce the most effective and natural stimulation of denervated musculature. This is an important step towards developing a prototype facial implant for use in humans with facial paralysis.

Abstract Body: Chronic complete facial paralysis is a debilitating condition with severe functional, aesthetic, and emotional consequences. There are a variety of surgical interventions available to help restore function and some movement to the paralyzed face, but there remains considerable room for improvement. Electrical implants provide a possible means of chronic stimulation to the denervated facial musculature. The creation and implementation of electrical facial implants requires extensive testing in an animal model under carefully controlled conditions. The purpose of this study was to develop a system allowing precise control over the delivery of electric current to rodent facial musculature using a thin-film microelectrode array.

Objective: 1. Begin to build a system for studying the electrical stimulation of denervated facial musculature in a rodent model; and 2. Understand the potential advantages of a thin-film microelectrode array for stimulating facial musculature.

Anticoagulants in the MOHs Reconstruction Patient
Chelsey J. Smith, MD; Ivan Wayne, MD; and Mariah Johnson
Core Competencies: Patient Care
Level of Evidence: Outcomes Research
Method: This is a retrospective study using information collected from January 2007 – December 2012 concerning patients who had wounds to the head and neck in need of reconstruction (the majority being post Mohs resection). There were a total of 569 patients assessed. Each patient was grouped into one of four categories: Group 1- No antiplatelet or anticoagulant therapy (448 patients); Group 2- Antiplatelet therapy only (98); Group 3- Anticoagulant therapy only (17); Group 4- Both antiplatelet and anticoagulant therapy (6). All post-operative bleeding complications were recorded and categorized as (1) addressed by patient at home/not witnessed by physician, (2) addressed by physician in clinic or ER, (3) return to OR for hematoma evacuation. There were a broad spectrum of procedures performed on these patients ranging from simple skin grafting to multiple facial flaps with cartilage grafting.

Results: Out of 569 patients, 15 had post-operative bleeding issues. 4 of these patients (two patients from group 1, one patient from group 2, and one patient from group 4) described bloody oozing that subsided while at home during their post-operative visit. 10 patients ( six from group 1, one from group 2, one from group 3, and two from group 4) had oozing at incision sites or small hematomas addressed in clinic or in the ER with no further complications. Lastly, only one patient from group 1 had to return to the OR for hematoma evacuation.

Conclusions: It is our practice to continue both antiplatelet and anticoagulant therapy in the peri-operative period for patients undergoing facial reconstructive surgery. Of the 15 patients who experienced a bleeding issue, 9 of these were allocated to Group 1 and took no blood-thinning agents on a regular basis. Also, the only patient to undergo hematoma evacuation in the OR was from Group 1. We conclude that reconstructive surgery of the head and neck with a primary focus on Mohs reconstruction can be performed without further management of thinning agents by a medical specialist or discontinuation of antiplatelet/anticoagulant. The risk of a serious post-operatively bleed is extremely low and most bleeding issues are able to be managed by the patient alone or in the clinic/ER setting. Our low bleeding complication rate coupled with less travel, medication management, post-operative clotting risk, and doctor visits (to medical specialists) allows for a more streamlined approach for both patient and facial reconstructive surgeon.

Abstract Body: Introduction: Many patients who undergo facial reconstructive surgery have multiple comorbidities requiring antiplatelet and/or anticoagulant therapy. It is common practice to have these patients evaluated by medical specialists to manage and discontinue their blood-thinning medications in preparation for surgery and to decrease intra-operative and post-operative bleeding. However, medication discontinuation does carry with it certain risks such as stroke, thrombosis, myocardial infarction, and embolism (dependent on the patients’ underlying comorbidities). This study stems from such events as post-operative complications like stroke which have been witnessed at our institution after
discontinuation of blood-thinning agents. We propose that the risks associated with discontinuing such medications are greater than those associated with post-operative bleeding. Objective: The objective of this study is prove that antiplatelet/anticoagulant therapy can be continued in the peri-operative period for patients undergoing facial reconstructive surgery without significant post-operative bleeding complications. Method: This is a retrospective study using information collected from January 2007- December 2012 concerning patients who had wounds to the head and neck in need of reconstruction (the majority being post Mohs resection). There were a total of 569 patients assessed. Each patient was grouped into one of four categories: Group 1- No antiplatelet or anticoagulant therapy (448 patients); Group 2- Antiplatelet therapy only (98); Group 3- Anticoagulant therapy only (17); Group 4- Both antiplatelet and anticoagulant therapy (6). All post-operative bleeding complications were recorded and categorized as (1) addressed by patient at home/not witnessed by physician, (2) addressed by physician in clinic or ER, (3) return to OR for hematoma evacuation. There were a broad spectrum of procedures performed on these patients ranging from simple skin grafting to multiple facial flaps with cartilage grafting. Results: Out of 569 patients, 15 had post-operative bleeding issues. 4 of these patients (two patients from group 1, one patient from group 2, and one patient from group 4) described bloody oozing that subsided while at home during their post-operative visit. 10 patients (six from group 1, one from group 2, one from group 3, and two from group 4) had oozing at incision sites or small hematomas addressed in clinic or in the ER with no further complications. Lastly, only one patient from group 1 had to return to the OR for hematoma evacuation. Conclusion: It is our practice to continue both antiplatelet and anticoagulant therapy in the peri-operative period for patients undergoing facial reconstructive surgery. Of the 15 patients who experienced a bleeding issue, 9 of these were allocated to Group 1 and took no blood-thinning agents on a regular basis. Also, the only patient to undergo hematoma evacuation in the OR was from Group 1. We conclude that reconstructive surgery of the head and neck with a primary focus on Mohs reconstruction can be performed without further management of thinning agents by a medical specialist or discontinuation of antiplatelet/anticoagulant. The risk of a serious post-operatively bleed is extremely low and most bleeding issues are able to be managed by the patient alone or in the clinic/ER setting. Our low bleeding complication rate coupled with less travel, medication management, post-operative clotting risk, and doctor visits (to medical specialists) allows for a more streamlined approach for both patient and facial reconstructive surgeon. Objective: Assess and change current clinical/surgical practices to better benefit reconstructive patients on antiplatelet and anticoagulant therapy; and compare the risk of post-operative hematoma in the anticoagulated patient versus the risk of stroke/embolism in the previously anticoagulated patient that has discontinued the use of this particular medication for surgery.

Determining the ideal side and plane to harvest the paramedian forehead flap: a cadaveric study
Sam P. Moubayed, MD; Marc-Elie Nader, MD; and Akram Rahal, MD
Core Competencies: (Medical Knowledge, Patient Care)
Level of Evidence: Outcomes Research
Method: Cadaveric dissection study on 8 fresh cadaveric heads.

The modified bilobed flap to decrease trapdoor deformity: a cadaveric study
Sam P. Moubayed, MD; Olivier Aboud, MD; MSc, Maxime Duranceau, DMD; Akram Rahal, MD; André Chollet, MD; and Christian Ahmarani, MD
Core Competencies: (Medical Knowledge, Patient Care)
Level of Evidence: Outcomes Research
Method: Cadaveric dissection study on 8 human heads. On all heads, bilateral 1 cm2 defects were created on the lateral nose and on the cheek. On 4 heads, rectangular bilobed flaps were performed on one side, and traditional bilobed flaps contralaterally. On the other set of 4 heads, triangular bilobed flaps were performed on one side, and traditional bilobed flaps contralaterally. Each head was used as its own control. The distortion of the cheek, cantho-narinary line, and ala were measured using digital photometric analysis. Distorsion was measured as the variation in percent in the original cheek surface area, and ala nasi, as well as the distance of displacement of the nasojugal fold.

Results: Mean flap surface area for the traditional bilobed (A), rectangular bilobed (B), and triangular bilobed (C) were 2.35 cm2, 2.92 cm2, and 2.59 cm2. Cheek surface area distortion was 1% for flap A, 8% for flap B, and 7% for flap C. The ala nasi distortion was 37% for flap A, 40% for flap B, and 40% for flap C. The nasojugal distortion distance was 0.38 cm for flap A, 0.32 cm for flap B, and 0.32 cm for flap C.

Conclusions: Straight-line bilobed flap results in an increased flap surface area, less so for triangular bilobed than for rectangular bilobed. The variation in cheek and ala nasi distortion was not significantly different between the modified and traditional bilobed flaps. There is a trend for increased nasojugal retraction with the traditional bilobed flap when compared to the straight-line bilobed. This might result in decreased trapdoor deformity clinically.
Abstract Body: The bilobed flap is a local skin flap used to reconstruct facial defects. This flap commonly results in a noticeable pinch effect or trapdoor deformity. We have developed a new bilobed design that avoids a curvilinear incision, and uses straight contours to decrease tissue distortion and the resulting trapdoor deformity.

Objective: 1. To describe the modification of the bilobed flap for facial defect reconstruction; and 2. To examine the resulting distortion of the surrounding skin on lateral nasal and cheek defects when comparing the modified bilobed flap to the traditional bilobed flap

A Congenital Hairy Polyp in the Setting of a Palatal Cleft: Report of a Case
Sydney C. Butts, MD; Laura Uwakwe, and Raavi Gupta, MD

Core Competencies: (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)

Level of Evidence: Case Series

Method: The review of the literature utilized several databases. An Ovid MEDLINE and PubMed search of the English language literature from 1960 to present, using the search terms “palatal cyst,” “congenital hairy polyp,” “dermoid and oral cavity,” “dermoid cyst and palate,” “congenital hairy polyp and cleft palate,” “cleft palate and lipoma/teratoma” was performed. Bibliographies from articles identified in this search were also reviewed to include additional articles published at earlier dates than the databases included. A review of the patient’s chart and pathologic results was performed. The SUNY Downstate Medical Center Institutional Review Board granted exemption from formal IRB review for this case report.

Results: The patient was the product of a 39-week gestation born via vaginal delivery. The mother denied any teratogenic exposures during the pregnancy. The patient’s examination revealed a cleft of the secondary palate. There was no known family history of clefting. The patient was admitted to the NICU for monitoring and for further evaluation of the cleft palate. Additional work up revealed a small patent foramen ovale that was deemed hemodynamically insignificant. The head and neck examination in the NICU revealed mild micrognathia consistent with Pierre Robin sequence. Her airway was stable and fiberoptic laryngoscopy showed no upper airway lesions. Upon discharge from the NICU, she was feeding well and continued to feed well and gain weight with the use of a special cleft feeder. The patient was seen for a genetic consultation at the age of 7 months.

Chromosomal karyotyping, fluorescence in situ hybridization and chromosome microarray were performed, revealing no chromosomal abnormalities and specifically no deletion at the 22q11 locus. No associated syndrome diagnosis was made. In clinical follow up prior to palatoplasty, a small irregular area along the right palatal shelf was observed but was asymptomatic and was stable at a subsequent follow up visit. The patient was scheduled for surgery to repair the cleft palate at ten months of age. Intra-operatively, the palatal cleft involved the soft palate and hard palate up to the incisive foramen. A pedunculated lesion within the palatal cleft was attached to right palatal shelf covered on the oral surface with hair-bearing skin. The lesion measured 1.5 cm in longest dimension and was attached via a narrow stalk to the anterior-most aspect of the right palatal shelf. The lesion was excised completely at its base. Intra-operative frozen section analysis suggested a dermoid lesion. The palatoplasty proceeded using the Furlow double opposing Z-plasty technique for repair of the soft palate cleft and a Bardach two-flap repair of the hard palate cleft. Given the width of the hard palate cleft, the hard palatal closure was reinforced by placing a thin piece of alloplastic dermal graft between the nasal and oral layers. The immediate post-operative course was uneventful. A stable, small fistula at the hard palate-soft palate junction (3 mm x 3 mm) is present, with no nasal reflux of liquids. Histopathologic evaluation of the lesion showed a polypoid skin covered nodule measuring 1.5 x 1.5 x 1.7 cm. Microscopic sections show a polypoid lesion covered with keratinizing epithelium and adnexal structures including hair follicles, sebaceous glands, and sweat glands. Underlying the epithelium, the connective tissue included collagen and lobules of adipose tissue. Minor salivary glands were present within the connective tissue of the stalk. There was no evidence of cartilage, bone or skeletal muscle. In this developmental lesion, with both ectodermal and mesodermal structures, the pathologic diagnosis is most consistent with a hairy polyp. Hairy polyps are rare masses that are grossly made up of skin and adnexal structures, and are histologically comprised of squamous epithelium and structures of ectodermal and mesodermal origin. They usually arise from the oropharynx or nasopharynx, and they seldom occur with other developmental abnormalities, such as a cleft palate, as in this case. It is also possible for other mass lesions to develop within the oropharynx or nasopharynx, obstructing the formation of a completely fused palate just as a hairy polyp can. The excision of these lesions is imperative, as they will continue to grow and may interfere with feeding and respiration. The pathogenesis of these lesions has not been completely defined. Their presentation also varies from indolent, asymptomatic lesions characteristic of this case presentation to large lesions at birth with associated respiratory difficulty. The review of the literature revealed ten other cases of hairy polyp associated with palatal clefts. All patients had cleft palate only, with no patients having cleft lip. Both benign and malignant lesions have been reported presenting with cleft palate including lipomas, rhabdomyosarcoma, dermoids/dermoid cysts, epidermoid cyst, epipalatal and teratomas. In instances where the hairy polyp is large at initial presentation and causing symptoms, early excision is the rule, with delayed repair of the palatal cleft. Complete excision results in complete extirpation, however one case in the literature did report a recurrence, requiring re-excision. Standard palatoplasty techniques can be applied to the cleft, which in this case was wide and despite approaches to decrease tension at the suture lines, a small fistula did develop.

Conclusions: Multiple congenital benign and malignant lesions may present in infants in association with a palatal cleft. Most entities are benign and while rare, it is important to understand the classification of these lesions, as terminology in the literature can be inconsistent. These congenital lesions have all been seen in the setting of palatal clefts only, underscoring the high degree of associated malformations in patients with palatal clefting.

Abstract Body: Orofacial clefts (OFCs) are among the most common congenital birth anomalies. Patients with OFCs will present with either cleft lip/palate or cleft palate alone. Patients with cleft palate have a higher rate of associated malformations and significant rates of syndrome diagnoses. The pathogenesis of some palatal clefts is explained by mechanical obstruction of the fusion of the palatal shelves. One of the best-studied clinical examples of this phenomenon is the wide palatal cleft that results in patients with Pierre Robin Sequence (PRS). In these patients, the superior positioning of the tongue during
Abstract Body: Congenital nasal bone aplasia is a rare condition that has seldom been reported in the medical literature. There is a single previous report of a familial autosomal dominant inheritance pattern of nasal bone aplasia. There are rare isolated cases of nasal bone aplasia reported as well. I present a case of nasal bone aplasia successfully treated with septal cartilage grafting to reconstruct the absent nasal bones. I also report an extensive family history confirming autosomal dominant inheritance pattern. Anatomical considerations will be presented as well as treatment options.

Objective: At the conclusion of this activity, the participant should be able to identify the rare genetic anomaly of nasal bone aplasia and understand the need to investigate other members of the family for this problem; and identify options for treating congenital nasal bones aplasia.

A Staging System for Revision Rhinoplasty
Regina Rodman, MD; and Russell Kridel, MD
Core Competencies: (Interpersonal and Communication Skills, Patient Care, Practice-based Learning and Improvement, Systems-based Practice)
Level of Evidence: Case Series
Method: Like the TMN staging, we describe 3 major components that determine the overall difficulty of the revision rhinoplasty surgery. In our system, P is for problem, the specific anatomical anomaly with which the patient presents. The second component to our system is G for graft, based on number of grafts required. The third component of this system is S, for the number of previous surgeries. Although patient attitude does not change the technical aspects of the surgery, it does add difficulty to case management and requires more energy by the surgeon to manage the patient in the pre and post operative period. For this reason, we have also added a rating A-D, for patient attitude, which is added after the Stage has been determined by the PGS classification.

Results: Example 1: 23 year old female, desires revision rhinoplasty for small midline bony dorsal hump noticed 7 weeks after primary rhinoplasty. Stage I: PG0S1A Problem- Under resected bony dorsum (1); Graft- none; Surgeries-one; Attitude- recognized limitations and is willing to accept improvement. Example 2- 46 year old male with history of excessive cocaine use and subsequent traumatic deformity, presents for further correction after primary rhinoplasty Stage IV: PSG4S2A Problem: Alar notching (5), alar...
asymmetry (5) septal perforation (5) nostril asymmetry (5) rim collapse (4), significant intranasal scarring (4). Graft: irradiated cartilage, multiple full thickness skin, composite ear cartilage. Surgeries: 2 at this presentation, (required 6 in total).

**Conclusions:** A staging system is needed to objectively stratify complexity of revision rhinoplasty for the benefit of the surgeon and to appropriately counsel patients. A Stage I revision might be repaired adequately by any surgeon who chooses to perform rhinoplasty, whereas a Stage IV revision may best be referred to the experienced revision rhinoplasty surgeon. The rhinoplasty prognosis is not measured in terms of survival, but what is possible versus an impossible surgical result. This pre-operative staging system may help the patient understand the complexity of the repair required and help manage expectations. Further, this system will facilitate exchange between revision rhinoplasty surgeons. A standardized evaluation system will allow for meaningful comparisons surgical techniques and evaluation of outcomes.

**Abstract Body:** Rhinoplasty is known to be one of the more technically challenging cosmetic procedures, and the rate of rhinoplasty revision reported in the literature ranges between 5-15%. Revisions may range from minor deformities that can be treated in the office to major cosmetic and functional defects that require multiple surgeries to correct. Review of the literature lacks a uniform scale which systematically evaluates the patient presenting for revision rhinoplasty. The TMN staging system for classification of malignant tumors was developed to aide the clinician in planning of treatment, give some information of prognosis, assist in evaluating the results of such treatment, and facilitate the exchange of information. Although the revision rhinoplasty patient does not present with a potentially lethal disease, a similarly standardized classification system may bring similar benefits of assigning qualitative value to these deformities, approximating the complexity of repair required, and facilitate comparison and discussion between rhinoplasty surgeons.

**Objective:** 1. Evaluate patient’s deformities who present for revision rhinoplasty; 2. Stratify different deformities into four stages based on anatomic anomaly, number of grafts potentially needed, number of previous surgeries, and patient attitude; and 3. Compare and contrast the four stages for surgical planning and well as managing patient expectations.

**Outcomes following Rhinoplasty with Autologous Costal Cartilage Grafts**
Prabhat Bhama, MD; Elliot Kozin, MD; Anne Clayman, and Jaimie DeRosa, MD; MS, FACS

**Core Competencies:** (Medical Knowledge, Patient Care, Practice-based Learning and Improvement)

**Level of Evidence:** Outcomes Research

**Method:** This was a retrospective cohort study of all patients who underwent rhinoplasty for nasal obstructive or cosmetic complaints by the senior author (JD) from 10/2009 to 4/2012. Nasal Obstruction Symptom Evaluation scores were recorded pre-operatively, 3 months post-operatively, and 1-year post-operatively. A questionnaire developed by the senior author was also administered in the post-operative setting. Patients who failed to complete questionnaires or those with incomplete questionnaires were excluded from the study.

**Results:** Fifty-six patients fulfilled the inclusion criteria. The mean age of the cohort was 34 years. Most patients (61%) were female. Thirty-nine percent of cases were revisions. Rib cartilage was used in over half of the cases. Over half of the patients in which rib cartilage was used were revision cases. The only complications encountered in this cohort were 2 cases of nasal infection. Over 80% of patients reported improvement in breathing and satisfaction with the aesthetic appearance of the nose post-operatively. There was no difference in recovery time between those patients who had costal cartilage graft and those who did not. Nasal obstruction septoplasty effectiveness scores at 1 year post-operative follow-up demonstrated a statistically significant improvement compared with the preoperative scores (p<0.0001).

**Conclusions:** Autologous costal cartilage graft is an effective method for augmentation rhinoplasty, particularly in revision cases. In this study, patients did not seem to require additional recovery time if costal cartilage graft was used.

**Abstract Body:** Objectives: To quantify morbidity and quality of life outcomes following rhinoplasty using autologous cartilage grafts with specific attention to use of costal cartilage grafts.

**Methods:** This was a retrospective cohort study of all patients who underwent rhinoplasty for nasal obstructive or cosmetic complaints by the senior author (JD) from 10/2009 to 4/2012. Nasal Obstruction Symptom Evaluation scores were recorded pre-operatively, 3 months post-operatively, and 1-year post-operatively. A questionnaire developed by the senior author was also administered in the post-operative setting. Patients who failed to complete questionnaires or those with incomplete questionnaires were excluded from the study. Results: Fifty-six patients fulfilled the inclusion criteria. The mean age of the cohort was 34 years. Most patients (61%) were female. Thirty-nine percent of cases were revisions. Rib cartilage was used in over half of the cases. Over half of the patients in which rib cartilage was used were revision cases. The only complications encountered in this cohort were 2 cases of nasal infection. Over 80% of patients reported improvement in breathing and satisfaction with the aesthetic appearance of the nose post-operatively. There was no difference in recovery time between those patients who had costal cartilage graft and those who did not. Nasal obstruction septoplasty effectiveness scores at 1 year post-operative follow-up demonstrated a statistically significant improvement compared with the preoperative scores (p<0.0001). Conclusion: Autologous costal cartilage graft is an effective method for augmentation rhinoplasty, particularly in revision cases. In this study, patients did not seem to require additional recovery time if costal cartilage graft was used. Level of Evidence: 3 (retrospective cohort study)

**Objective:** quantify morbidity and quality of life outcomes following rhinoplasty using autologous cartilage grafts with specific attention to use of costal cartilage grafts.

**The Effect of Depressor Septi Resection in Rhinoplasty on Upper Lip Length**
Yan Ho, MD; Robert Deeb, MD; Richard Westreich, MD; and William Lawson MD; DDS

**Core Competencies:** Medical Knowledge

**Level of Evidence:** Case Series

**Method:** A retrospective chart review and photographic analysis was performed on 50 patients who had undergone rhinoplasty involving resection of the depressor septi by one of the 2 senior authors (R.W and W.L.). All maneuvers performed during the procedure were recorded and pre-operative photos were compared to post-operative photos using Adobe Photoshop CS4 Extended Version 11.0.2 and percent change of upper lip length was calculated.

**Results:** 50 total patients were evaluated. The mean percent
change was a 3% decrease in lip length. 29.6% had an increase in their upper lip length. Among these patients the mean percent increase was 4.7% (SD=2.93). The remaining 70.4% had a decrease in length. Among these patients the mean percent decrease was 5.25% (SD=4.98). Among female patients, the mean change was a 1.1% (SD=5.66) decrease in lip length. In male patients, the mean change was a 3.9% (SD=7.56) decrease. However, this difference was not statistically significant (p=0.091). There were no predictable factors to determine whether a patient would develop a post-operative increase or decrease in upper lip length.

Conclusions: Resection of the depressor septi muscle during rhinoplasty is a well-documented maneuver often used in the treatment of the ptotic tip and smile deformity. This descriptive study showed that resection of the depressor septi muscle has unpredictable but somewhat negligible effect on upper lip length in the repose position.

Abstract Body: Objectives: To define an approach to the resection of the depressor septi muscle during functional and aesthetic rhinoplasty and to determine if performing this maneuver causes any measurable change in the length of the upper lip in the repose position.

Methods: A retrospective chart review and photographic analysis was performed on 50 patients who had undergone rhinoplasty involving resection of the depressor septi by one of the 2 senior authors (R.W and W.L.). All maneuvers performed during the procedure were recorded and pre-operative photos were compared to post-operative photos using Adobe Photoshop CS4 Extended Version 11.0.2 and percent change of upper lip length was calculated.

Results: 50 total patients were evaluated. The mean percent change was a 3% decrease in lip length. 29.6% had an increase in their upper lip length. Among these patients the mean percent increase was 4.7% (SD=2.93). The remaining 70.4% had a decrease in length. Among these patients the mean percent decrease was 5.25% (SD=4.98). Among female patients, the mean change was a 1.1% (SD=5.66) decrease in lip length. In male patients, the mean change was a 3.9% (SD=7.56) decrease. However, this difference was not statistically significant (p=0.091). There were no predictable factors to determine whether a patient would develop a post-operative increase or decrease in upper lip length.

Conclusions: Resection of the depressor septi muscle during rhinoplasty is a well-documented maneuver often used in the treatment of the ptotic tip and smile deformity. This descriptive study showed that resection of the depressor septi muscle has unpredictable but somewhat negligible effect on upper lip length in the repose position.

Objective: describe the effect of resecting the depressor septi nasi on upper lip length in repose.
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Bourbon Street

So much of what makes New Orleans unique is captured in the melting pot atmosphere of the French Quarter - from the raucous party atmosphere of Bourbon Street to the bohemian elegance of Royal. It's a neighborhood full of surprises and magic.

When the French engineer Adrien de Pauger laid out the streets of New Orleans in 1721, he chose one to carry the name of the French Royal Family ruling at the time - Rue Bourbon. Since then, Bourbon Street has become one of the most recognizable party destinations in the world.

History tells us that over the years Bourbon Street has been home to vaudeville, burlesque, jazz joints and gentlemen's clubs - serving as inspiration for the bawdy, party atmosphere the street is known for today. But visitors may be surprised to find that Bourbon offers more than the obvious nightlife options. In addition to venues featuring bands covering your favorite songs and exotic striptease clubs, the street is also home to traditional jazz clubs, upscale lounges and historic restaurants - it all depends on what you're looking for.
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Congratulations to the new and upgraded AAFPRS members (June 2012 to May 2013)

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Congratulations to the following AAFPRS members for receiving research grants and awards from the AAFPRS Foundation.

- **2013 Leslie Bernstein Investigator Development Grant, $14,964**
  - P. Daniel Ward, MD
  - An Implantable Neuroprosthesis for Facial Reanimation

- **Leslie Bernstein Resident Research Grant, $5,000**
  - Meir David Hershcovitch, MD
  - Enhancing Peripheral Nerve Repair with a Bioresorbable Metal

- **Sir Harold Delf Gillies Award**
  - Marc H. Hohman, MD

- **Motor Nerve Cable Grafting Permits Recovery Equivalent to Primary Neurorrhaphy in a Rodent Facial Nerve Model**
  - Amy L. Pittman, MD
  - Stomal Recurrence: Salvage Surgery and Reconstruction

- **John Orlando Roe Award**
  - Randall A. Bly, MD
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480-619-4071, fax
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Ulthera®, Inc. is a global medical-device company pioneering aesthetic and medical applications using its ultrasound platform technology. The Ulthera® System is the only energy-based device to receive FDA-clearance for a non-invasive aesthetic lift indication. The first application for the System’s procedure, Ultherapy®, is a facial treatment to achieve brow lifting.

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The Howard W. Smith Legacy Society recognizes individuals, foundations, and corporations whose cumulative life-time gifts to the AAFPRS Foundation and the FPS Fellowship Examination Corporation total $50,000 or more. Those who achieved this goal by the fall of 2004 were accorded the status of charter members in the society, which was founded in 2002. The Howard W. Smith Legacy Society 2013 member list:

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13. Stephen Perkins, MD
14. Harrison C. Putman III, MD
15. Vito C. Quatela, MD
16. Thomas Romeo, MD
17. David B. Rosenberg, MD
18. William E. Silver, MD
19. Dean M. Toriumi, MD
20. Edwin F. Williams III, MD
21. William J. Wolfenden, Jr., MD**
ABOUT THE AAFPRS
ITS HISTORY
The American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) was founded in 1964 and represents more than 3,000 facial plastic and reconstructive surgeons throughout the world. The AAFPRS is a National Medical Specialty Society of the American Medical Association (AMA). The AAFPRS holds an official seat in the AMA House of Delegates and on the American College of Surgeons board of governors.

ITS MEMBERS
The majority of AAFPRS members and fellows are certified by the American Board of Otolaryngology-Head and Neck Surgery, which includes examination in facial plastic and reconstructive surgery procedures, and the American Board of Facial Plastic and Reconstructive Surgery. Other AAFPRS members are surgeons certified in ophthalmology, plastic surgery, and dermatology.

ABOUT THE AAFPRS FOUNDATION
In 1974, the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS Foundation) was created to address the medical and scientific issues and challenges which confront facial plastic surgeons.

The AAFPRS Foundation established a proactive research program and educational resources for leaders in facial plastic surgery. Through courses, workshops, and other scientific presentations, as well as a highly respected fellowship training program, the AAFPRS Foundation has consistently provided quality educational programs for the dissemination of knowledge and information among facial plastic surgeons.

In the early 1990s, FACE TO FACE humanitarian programs were established so that AAFPRS members could use their skills and share their talent in helping the less fortunate individuals here and abroad.

• FACE TO FACE: International brings AAFPRS members to third world countries where they treat children with facial birth defects and anomalies.

• FACE TO FACE: The National Domestic Violence Project allows AAFPRS members to perform surgeries on survivors of domestic abuse here in the United States, who have received injuries to their faces.

• The newest member to FACE TO FACE is FACES OF HONOR. This program offers free surgical care for soldiers who have been injured in the line of duty in Iraq and/or Afghanistan.

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+ Non-voting member of the Executive Committee

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Patrick J. Byrne, MD, Eastern Regional Director-elect (2016)
David W. Kim, MD, Western Regional Director-elect (2016)

PAST PRESIDENTS

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<tr>
<th>Year</th>
<th>Name</th>
<th>Specialty</th>
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<tr>
<td>1986</td>
<td>E. Gaylon McCollough, MD</td>
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