Sunscreens and Sun Protection

Overview

Protection from the sun is important to most individuals, especially cosmetic surgery patients. Proper sun protection prevents not only skin cancer, but also premature photoaging of the skin (i.e., wrinkling, solar elastosis, atrophy, telangiectasias, and lentigines). Individuals who have had cosmetic surgery to correct these problems need protection to prevent them from recurring.

Patients first should be cautioned to avoid the sun during the peak hours of the day, generally between 10:00 AM and 3:00 PM, if possible. In addition, protective clothing such as long pants, long-sleeved shirts, and broad-brimmed hats should be worn as feasible. Sunglasses that provide protection from ultraviolet (UV) radiation should be worn to protect the periorbital skin, eyelids, corneas, and lens. All areas that cannot be protected as previously described should be covered with a sun screening agent.

Sunscreen Formulations

Sunscreen formulations contain chemicals that absorb UV radiation and can include para-aminobenzoic acid (PABA) and its derivatives, benzophenones, cinnamates, and salicylates. Although some patients have skin that is sensitive to PABA, this substance remains an effective sun screening agent. Physical sunblocks contain zinc oxide or titanium dioxide, which form a barrier between the sun and the skin. The sun protection factor (SPF) is the measurement of a sun screening agent's relative effectiveness in blocking UV radiation. A sun screening agent with an SPF of 15 allows an individual to remain in the sun 15 times longer without burning compared to exposure without sunscreen.

“"For most patients, I recommend a waterproof, high-SPF, PABA-free sunscreen in a moisturizing base, . . . ”

Sunscreen Myths

Myth No.1
It is unnecessary to use a sunscreen with an SPF greater than 15. This is probably true for an individual's everyday use without perspiration or participation in water sports. However, high SPF sunscreens are indicated for those who do a lot of swimming or participate in strenuous outdoor activities in which they perspire heavily. I usually recommend sunscreens with SPFs of 30 to 50 for these patients.

Myth No.2
Sunscreens cause cancer. No evidence exists that sunscreen chemicals, when applied to the skin of humans, cause skin cancer.

Myth No.3
Sunscreens do not prevent melanoma. This misconception is based on a faulty study in which mice were injected with melanoma cell lines and then treated with sun screening agents after being exposed to UV radiation. To no one's surprise, the melanoma continued to grow despite sunscreen. Sunscreens have never been considered chemotherapeutic agents that treat cancer but are helpful in its prevention.

Myth No.4
Waterproof sunscreens do not come off in water. The term "waterproof" actually refers to the persistence of the stated SPF after a maximum of 80 minutes of immersion in water. Therefore it is generally recommended that individuals reapply the sunscreens approximately every hour and a half when they are perspiring or swimming.

Choosing a Sunscreen

For most patients, I recommend a waterproof, high-SPF, PABA-free sunscreen in a moisturizing base, such as Pre-Sun 29®, Shade 45®, Coppertone 45®, or Solbar PF Ultra 50®. These sunscreen products are appropriate for individuals who have dry or photoaged skin.

continued on page 110
Medial Thigh Surgery

"Surgical Strategies" focuses on refinements in aesthetic surgical techniques. Contributors are Aesthetic Society members or other recognized experts.

The medial thigh aesthetic deformity presents a challenging problem to the surgeon performing body contouring. Skin laxity of the medial thigh is frequently the earliest sign of aging in the thighs and is one of the first signs of significant ptosis in the body. The skin in the medial thigh is quite thin and inelastic, resulting in early relaxation with age and poor retraction after liposuction. Liposuction of moderate to severe fat deposits in the medial thigh often leads to skin laxity, especially after the age of 30. Skin laxity requires excisional surgery to produce consistent improvement in medial thigh contours.

Factors resulting in early gravitational descent of the medial thigh tissues include a heavy fat deposit supported by thin and weak fibrous structures—the superficial fascial system (SFS)—and the skin—along with a loosening of the two anchors of the anteromedial thigh. First, the perineal-thigh crease descends inferiorly with age because of loosening of its fibrous attachments to the perineal SFS (Colles’ fascia). This results in the flat vulvar contour of older women along with medial thigh ptosis.

The importance of a second anchor of the anteromedial thigh tissues has been noted since the development of the high lateral-tension abdominoplasty. Relaxation of the lower abdominal and inguinal tissues results in laxity of the anteromedial thighs. A strong lift of the lateral abdominal-inguinal region will provide an indirect lift of the anteromedial thigh.

Surgical Strategies

In the second and third decades of life the medial thigh deformity consists primarily of a localized fat deposit that can be adequately managed in most cases by liposuction. Even some degree of skin laxity may be noted after liposuction. Patients should understand the anatomic limitations in this region and the possible need for a medial thigh lift in the future. This discussion should help prevent unrealistic expectations in medial thigh contouring.

In the fourth decade of life actual or potential skin laxity of the medial thigh generally appears in most women and continues to progress thereafter. Medial thigh flaccidity may be isolated but more commonly is associated with laxity of the lower abdominal and inguinal regions. Patients with significant laxity isolated to the medial thigh, with or without a localized fat deposit, will require medial thigh lifting and, if necessary, liposuction.

For patients with laxity of both the lower anterior trunk and upper anteromedial thighs, I now recommend the high lateral-tension abdominoplasty as the initial procedure in most cases. This provides a modest lift of the anteromedial thigh tissues, which is often enough to allow simultaneous liposuction of any upper medial thigh fat deposits. Patients should understand that medial thigh lifting may be required in the future for optimal medial thigh contour. Patients with moderate to severe medial thigh laxity will definitely require medial thigh lifting at the time of abdominoplasty or at a later stage.

Performing an effective medial thigh lift in the presence of inguinal/pubic tissue laxity will result in an unaesthetic folding of these tissues over the anterior portion of the incision. This can be readily demonstrated to patients while they are standing in front of a full-length mirror. Patients can also visualize the improvement in anteromedial thigh contours with a strong lift of the lateral abdominal/inguinal regions.

Medial Thigh Lift

Whereas standard medial thigh lift techniques were often plagued with widened and migrating scars, vulvar distortion, and ineffective lifts, the Colles’ fascial anchoring technique reduced the risk of such complications, producing more consistent and long-lasting results. Since originally describing the anchoring technique 9 years ago, numerous technical refinements have been developed to enhance safety, predictability, and aesthetics.

Colles’ Fascial Anatomy

Colles’ fascia is a distinct, strong fascial layer that attaches to the periosteum of the ischiopubic rami of the bony pelvis and defines the perineal-thigh crease. It is continuous with Scarpa’s fascia in the pubic area and has subcu-
taneous fascial extensions that help form the buttoc k fold posteriorly. All of these subcutaneous connective tissues are part of the SFS and all are used to anchor the medial thigh lift procedure.

**Design Changes**

The medial thigh lift design has changed significantly since the original description because of a better understanding of thigh aesthetic deformities. Because most skin laxity in this area occurs at the juncture of the anterior and medial thighs, the standard surgical resectional pattern has rotated anteriorly, allowing the entire procedure to be performed in the supine position. In contrast to previous descriptions, the incision should not extend into the buttoc k fold posteriorly. For most aesthetic deformities the incision leaves the perineal-thigh crease at the pubic tubercle and courses vertically along the lateral margin of the mons pubis, staying within bikini lines. For milder cases, the medial thigh lift incision is more limited, extending anteriorly to just beyond the pubic tubercle.

**Technical Refinements**

Preoperative markings are made in the standing position with the knees apart. The extent of medial thigh fat deposits is marked and an estimate of the amount of skin redundancy is determined. The actual skin resection has become more conservative over the years, averaging 5 to 7 cm of stretched skin at the anteromedial corner of the thigh. Anchoring the perineal-thigh crease into Colles' fascia provides an additional 3 to 5 cm of lift. More conservative resection has decreased wound complications from overresection while providing consistent contour improvements.

The patient is placed in the supine position with the hips flexed 30 degrees. Stockinette s with elastic wraps are placed to the knees, so that the thighs can be repositioned during surgery. The excision of redundant tissue and the subsequent repair are performed with the patient's knees shoulder-width apart (rather than in the semi-frogs leg position) to avoid undercorrection. The thigh can be ab ducted for exposure as needed.

Initial deep liposuction after infusion with dilute epi nephrine in lactated Ringer's solution is followed by skin-only incision along the superior resection line. Posteriorly, the incision extends only to the far posterior perineal-thigh crease. Anteriorly, the incision leaves the perineal-thigh crease at the pubic tubercle (origin of adductor longus muscle) and courses vertically along the lateral aspect of the mons pubis to varying degrees, defining the new lateral limits of the pubic hair pattern (Figure 1).

Undermining the thigh flap posterior to the pubic tubercle is performed superficial to the adductor muscle fascia. Undermining extends 3 to 4 cm beyond the planned line of resection. Anterior to the pubic tubercle, the undermining is more limited and is superficial (8 to 10 mm subdermally) over the soft tissue bundle that extends from the pubis to the femoral triangle. Preserving these external pudendal blood and lymphatic vessels reduces the risk of lymphatic complications (Figure 2).

Colles' fascial roll is now identified by blunt gauze finger dissection over the adductor muscle fascia, pushing superiorly until the ischiopubic ramus is palpat ed at the f ingertip. Do not dissect beyond this level; attempts to overly define this vague superficial fascial roll may lead to disruption of the fibrous elements anchoring Colles' fascia to the ischiopubic ramus. Retracting the skin and superficial fat of the vulva medially will expose Colles' fascia.
fascial roll at the deepest and most lateral aspect of the vulvar soft tissues.

Permanent anchoring sutures from Colles’ fascia to the thigh flap SFS are now used for all patients (0-braided nylon, dipped in povidone iodine [Betadine®], taper needle) (Figure 3). Anterior to the pubic tubercle, Scapka’s fascia is used for the deep anchor after bluntly dissecting through the preserved soft tissue bundle. Posteriorly, the buttock fold SFS anchors the medial thigh flap to prevent scar descent out of bikini lines. To hold the thigh flap in position more securely, the braided nylon anchoring suture is now placed into the thigh SFS and dermis instead of in the dermis alone as initially reported.1 The actual incisional closure line is forced onto the relaxed vulvar tissues to decrease the risk of scar widening or migration.

No drains are used. Light gauze dressings are applied and changed as needed. Dressings are removed in 1 to 2 days. The incisions are cleaned with peroxide or soap and water twice a day and then coated with a thin layer of silver sulfadiazine (Silvadene®) cream to reduce bacterial growth in the perineal-thigh crease. No compression garments are used.

In conclusion, the surgical principles of the medial thigh lift have evolved to allow more accurate patient selection, individualized operative planning, and standardized surgical technique.

References


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Outcomes Studies and Aesthetic Surgery

What are outcomes studies and what have they to do with aesthetic surgery?

Bruce L. Cunningham, MD, Minneapolis, MN, discusses outcomes studies and their use in aesthetic surgery.

The outcomes study is a medical information tool that health care payers hope will enable them to make better decisions about purchasing health care services by statistically defining value in the medical marketplace. Its origin was driven by the need for competitive, market-mediated health cost containment. The outcomes study serves both as an index to the relative effectiveness of different treatments and as a monitoring tool to detect and remedy potential deterioration in the quality of care resulting from overzealous rationing of resources by managed care providers. Today, outcomes studies are increasingly viewed by policy makers as a mechanism to ensure a minimum quality of care rather than to stimulate and reward excellence. The defining equation of the outcomes movement is Value = Outcome/Cost. Note that restrictions in cost may not provide incentive for true excellence in quality of care.

To a large degree, the emergence of outcomes studies was a logical response by payers to the wide and seemingly illogical variations seen, both nationally and regionally, in physician practice patterns. With such variance, it became essential to determine which therapies were of greatest worth and value and to establish guidelines that would direct all medical practices toward recognized and accepted standards. Competing individual practices would have to provide data that would allow comparison with the established benchmark values. Dr. Paul Ellwood, recognized as the progenitor of the outcomes movement, ascertained the need for medicine to establish a “central nervous system” that could integrate the complexities of modern medicine.

The very definition of outcomes studies has been shifted by this change in the vantage point of measurement. In the past, the physicians alone defined outcomes, measuring the result in clinical parameters of interest to them. However, in the new marketplace, “counting the dead is not enough,” and new measures that record dimensions of outcomes that are more patient- and consumer-oriented have been deemed essential. Capturing the “view from the bed” is a vital component in determining value in the marketplace because it asks “consumers” to assess the global dimensions of their health: physical and psychologic functional status, sense of well-being, and satisfaction with the quality and delivery style of care.

Tools and Methods

The tools and methods of this new data-collecting discipline are different from those that were available in the past. The classic model for clinical assessment, the double-blind controlled study, is deficient because it collects data in the rarefied atmosphere of the research center and does not reflect medicine as it is really practiced. New study instruments are standardized to reliably capture the global dimensions of health care across a diverse population and have had to be readily integrated within the context of the average physician’s practice style.

In addition to capturing such data as patient satisfaction, well-being, and functional status, which are common to most outcomes studies, instruments are designed to identify specific parameters of the particular disease being studied. Thus an outcomes study assessing breast reduction would include a standardized measurement of general health status, such as the Rand SF-36, and a battery of questions related to the consequences of massive breast size. After surgery, the patient would again be assessed to determine the benefit versus the cost of the intervention.

The consumers’ appraisal is intuitively obvious to aesthetic surgeons who are used to having their value set
directly in the marketplace. It is clear to us that patients benefit from aesthetic surgery in many intangible, but extremely important ways, and it is an advantage for us that the marketplace is learning to quantify these parameters. Does our unique identity within the mosaic of medicine, however, allow us to disdain outcomes studies?

What Do Outcomes Studies Have to Do With Aesthetic Surgery?

Aesthetic surgeons must take note of the outcomes movement as it presages three trends in medicine that will impact increasingly on the future of our specialty. First, most of us are not in a position to ignore the forces of managed care. We must validate common procedures such as breast reduction, corrective rhinoplasty, blepharoplasty for visual field obstruction, and many others so that they remain reimbursed procedures within our practice. Once participating within the managed care world, we will be compelled to measure our own practices against established benchmarks for procedures we perform. These benchmarks will be established by others if we ignore the trend.

Second, aesthetic surgeons who have outcomes data will be in the best position to demonstrate their value directly to consumers in the face of competition from other providers of aesthetic surgical services. The ability to present data to demonstrate patient satisfaction, quality of care, cost-effectiveness, and the other parameters that outcomes studies can measure will provide factual distinction of our abilities. Viewed as a commitment to intelligent marketing in the age of information, validated outcomes data will reassure the consumer in a format they have become accustomed to.

Finally, we cannot assume that our sanctum of purely aesthetic procedures will be neglected by the forces of managed care. Managed care plans need to distinguish themselves. In some regions providing “premium service enhancements,” such as fertility therapy, psychologic care, health club enrollment, and other services, at reduced rates to subscribers have been discussed. Can “premium” aesthetic surgery services be far behind? With the overabundance of providers available and willing to work, payers will find a source for “discounted aesthetic surgery services.” Despite our desires and tradition, we will have to provide outcomes data to compete for a share of these contract services or risk being supplanted by others.

Most aesthetic surgeons have more experience than they realize with the outcomes study that reaches beyond the simple “patient satisfaction” or “physician satisfaction” tools of recent years. The efforts to validate the benefit of saline and silicone implants are a paradigm for incorporating outcomes discipline into current practice patterns. Organized plastic surgery has developed or appropriated several outcomes instruments that will soon be available nationally. In the future, participation in outcomes activities will represent the most intelligent tool for assessing, promoting, and marketing the value of our services.

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Lower Lid Transconjunctival Blepharoplasty Using the Colorado® Needle

I generally perform blepharoplasty procedures in my office with the patients under local anesthesia. First, to prepare the patient, I numb the lower lid. I usually place a corneal scleral protector over the eye and use a Jaffe speculum to keep the upper lid out of the field. I put a Blair retractor on the lower lid and pull it away from the globe. Using the Colorado® needle (Colorado Biomedical, Inc., Evergreen, CO) tip (Figure) in the coagulation mode, I make a spot about 4 mm below the inferior tarsal border. There tends to be a lot of bleeding in this area, so I use the low-voltage coagulation mode to mark my incision line. I then switch to the cutting mode and go through the conjunctiva and lower lid retractors. After I create a flap, I usually place a 4-0 silk suture in the conjunctiva and lower lid retractors and pull them up onto the head drape for traction. Then I slowly advance the Blair retractors downward until I’m in the fat compartment. Once the fat pads are identified, I grasp these with the forceps.

I use the coagulation mode of the electrosurgical unit and the Colorado® needle to perform an open sky lipectomy. Ninety-nine percent of the time I identify the inferior oblique muscle and work around it. By using the coagulation mode, I can usually avoid any clamping of the fat and have very little, if any, bleeding.

After I feel that I have removed a sufficient amount of fat from both lids, I use the coagulation mode again to “fine-tune.” For example, if I compare the medial compartment on the left lid with that on the right and find that one is bulging a bit more than the other, I’ll use the coagulation mode to shrink the fat. A comparison as such is done to each compartment of fat, which is then “fine-tuned” as needed until perfect symmetry is achieved. Then I use a few 6-0 interrupted fat-absorbing gut sutures to close the conjunctiva and that completes the procedure.

Regarding the management of the eyelid skin, it really depends on the patient’s characteristics. On younger patients who have just fat deposits and no skin laxity, I perform a transconjunctival blepharoplasty only. I’m doing fewer and fewer external transcutaneous blepharoplasties. If the patient needs skin laxity corrected, I perform a transconjunctival blepharoplasty and then concomitant laser resurfacing.

Compared with the cold steel, the Colorado® needle and CO₂ laser both provide a more bloodless field, which enhances the efficiency and precision of the entire operation. I rarely use cold steel for cutting, with the exception of perhaps the initial skin incision in younger people. On older patients, I use the Colorado® needle in the pure cutting mode to create the initial skin incision, regardless of the location. The Colorado® needle or the CO₂ laser would achieve the same result. However, I think the set up of the large laser machine and the articulated arm presents the main disadvantage of using the CO₂ laser; the Colorado® needle simply allows better ergonomics. In addition, the costs are lower, there’s no scattered light beam, and the surgeon doesn’t need protective eyewear or special equipment.

Left photo, Colorado® needle. As shown in right photo, the tip of the Colorado® needle is much finer than the tip of the standard electrocautery needle.

Jeffrey C. Popp, MD, Omaha, NE, is a board-certified ophthalmologist who performs facial plastic surgery.

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Lower Lid Transconjunctival Blepharoplasty
Using the CO₂ Laser

A significant number of lower blepharoplasty candidates are best treated with transconjunctival blepharoplasty combined with laser skin resurfacing. The purpose of performing a transconjunctival blepharoplasty is to remove fat from the lower eyelid without touching, and thereby damaging, the septum. If you remove the fat by going through the skin, you will have to manipulate that septum. Avoiding the septum reduces the potential for lid retraction.

After my staff dons the appropriate eye protection and the patient is “prepped” sufficiently and draped properly, rather than insert a retractor, my assistant pulls the eyelid inferiorly, exposing the inferior cul-de-sac and conjunctival surface. A Jaegar plate, which is burnished so that it does not reflect the laser, is used both to protect the cornea and to displace the globe posteriorly to prolapse fat up into the cul-de-sac. I make two passes with the CO₂ laser, which is usually set in the continuous mode, and for this incision I use 6 watts. The first pass begins in the caruncle medially, continues about 4 mm inferior to the inferior tarsal margin, and proceeds all the way out to the lateral canthus. The second pass, which simply deepens the incision, extends through the lower eyelid retractors; this exposes the fat, which begins to prolapse into the wound. I then insert a small burnished Desmarres retractor to retract the lower eyelid. This retractor will diffuse, rather than reflect, any laser light that hits it. Next, I pull the lower eyelid retractors superiorly out of the wound, which brings the fat up with it.

At this point I can just stroke the fat to determine the position of the delineating landmarks—the inferior oblique muscle separating the medial fat pocket from the central fat pocket and the arcuate expanse of the inferior oblique muscle between the central and lateral fat pockets. I amputate each of these three fat pockets—ideally with a single laser pass—by holding the laser and draping the fat with the surgeon’s nondominant hand across the Desmarres retractor. I bring the fat to the retractor so that I don’t have to move the laser very much. The fact that you have an articulating arm is really not a problem; the arm floats easily and you don’t move it very much because you move the fat across the Desmarres retractor. I can now determine the additional amount of fat that needs to be removed. To accomplish this, I remove the retractor and look at the external aspect of the eyelid to see whether redundant fat is still apparent. If so, the Desmarres retractor is reinserted again and fat can be removed from whichever of the three fat pockets appears to have too much fat. The end point is when the fat has been removed down to and flushed with the inferior orbital rim. No sutures are placed, and I simply move on to the next eyelid.

Often, the skin is best managed with laser resurfacing. In the past, I was combining chemical peeling with transconjunctival blepharoplasty. However, I have since learned that laser resurfacing can produce the same result as chemical peeling, but in a much more technically controlled and reproducible manner with significantly less potential for complications.

Laser surgery is precise and is faster and safer than conventional surgery. Using the laser beam for cutting and coagulation allows one to remove fat and cut tissues with minimal thermal spread, minimal hemorrhage, and minimal ecchymosis. The laser also seals the lymphatics and therefore engenders significantly less inflammation and edema. Patients recover faster and can return to work sooner with significantly fewer signs of surgery compared with those who undergo the Colorado® (Colorado Biomedical, Inc., Evergreen, CO) needle blepharoplasty procedure.

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The Persistence of Repeated Errors

A review of the past four annual plastic surgery claims review panels shows a disappointing persistence of the same complaints. It is always the hope of any risk manager that the distilled wisdom gained from past mistakes, intensely relevant to the daily practice of plastic surgeons and transmitted in an intelligible fashion, will have some effect on future behavior. Regrettably, in the case of aesthetic surgery claims, it has not. Despite numerous efforts to stimulate awareness among our colleagues, we are still plagued with persistently poor documentation and preoperative photographs, inadequate informed consents, and insufficient patient selection criteria. Following are some examples of what gives medical malpractice risk management people acute heartburn.

Smoking
Despite repeated warnings, a continual flow of totally avoidable claims directly linked to smoking still occurs. In at least three recent cases involving wide tissue undermining procedures, such as face lift and breast surgery, the patients were heavy smokers. As a result, they suffered sloughs or sloppy healing, causing poor scars. If a patient is a heavy smoker (a pack or more per day), the surgeon should consider declining or postponing surgery or should carefully document that the patient was warned of possible complications if he or she continued to smoke. If the surgery is to proceed after a “no smoking” period, we advise at least a 1-month postponement and a separate statement signed by the patient stating that he or she has not smoked for that period.

One such case involved a 35-year-old patient who saw her aesthetic surgeon for breast reduction surgery. Her breast size at that time was 40EE, and this caused pain across her back and up her neck. The surgeon, who had advised the patient to stop smoking 1 month before surgery, performed a bilateral breast reduction without incident. Ten days later the patient was seen in follow-up, and a full-thickness necrotic area was noted on the right breast. Two weeks after that he performed a debridement of the patient’s left nipple and a skin graft from the right groin to the right breast. He then continued to monitor the patient with antibiotics and dressing changes. In the next 3 weeks she had drainage and inflammation of the left breast. Her surgeon did note that the patient was noncompliant with postoperative instructions to cease smoking during the recovery period.

This case is defensible because the doctor properly documented that the patient was a smoker and gave appropriate preoperative and postoperative instructions to refrain from smoking 1 month before surgery and during recovery. The patient’s complications were seen as “contributory negligence” caused by her failure to comply with the instructions. A defense verdict was obtained.

Documentation
Proper documentation is crucial in elective aesthetic surgery. In one typical case, a septrhinoplasty was performed with unsatisfactory results. Although the medical records indicated the performance of a septrhinoplasty, no operative report indicated that the septal part had been done. The case was further compounded by additional elective surgeries whose justification was dubious, if not contraindicated.

In several complex cases reviewed, there were no preoperative photographs. Because ours is such an intensely visual specialty, the presence or absence of good clear preoperative and postoperative photos can spell the difference between a case being dismissed or a hefty plaintiff’s verdict. In one such case where the plaintiff alleged breach of contract and medical negligence because augmentation had failed to give her the result she had...
expected, photography saved the day. The judge looked at the photos and granted the surgeon’s motion for dismissal. In another case, however, despite the surgeon’s allegation that facial asymmetry existed preoperatively, the crooked smile after the face lift could not be documented because no preoperative patient photos were available. The jury came back with a plaintiff’s verdict.

**Informed Consent**
The level of adequate informed consent documentation among our insureds has improved significantly over the last few years. Informed consent plays a critical role in virtually all aesthetic surgery cases. You are strongly encouraged to spend as much time as necessary with a patient to make sure he or she fully understands all aspects—pro and con—of the surgery being requested.

In two cases of facial rhytidectomy, the patients complained of a loss of sensation in the ear. In both cases the patients stated that they were not advised of the potential for nerve damage. In one of these cases, the surgeon obtained a consultation from a neurologist, who reported that the patient had sustained “nerve damage, secondary to face lift.” The surgeon should have referred the patient to a plastic surgery colleague who would have understood the temporary nature of the injury and would have so advised the patient. In this case, the words “nerve damage” were enough for the attorney to think he had a valid case.

Another illustrative case involved a surgeon’s assumption that because the patient was an educated critical care nurse, the amount of information given to her to obtain her consent did not need to be as extensive as usual. This 30-year-old nurse was seen for a strong family history of breast cancer. She requested a prophylactic subcutaneous bilateral mastectomy. The insured surgeon assumed that the patient understood more than the average layperson, and he performed the procedure with an immediate postoperative reconstruction. Postoperatively, the patient developed congestion and ecchymosis bilaterally in the skin flaps, and the left implant migrated toward the left axilla. Two days postoperatively the left implant was repositioned, although the skin flap appeared to be of questionable viability and the nipple appeared necrotic. Two weeks later, additional problems developed with the left implant, and it finally had to be removed. The right implant was removed 3 weeks later, and a debridement of nonviable tissue had to be performed. The plaintiff alleged bilateral breast disfigurement. In reviewing the records the insurance company found a distinct lack of documentation or evidence of discussion with the patient about possible postoperative complications. Under the circumstances, the case was judged difficult to defend, and a settlement was sought. A surprisingly high percentage of plastic surgery claims involve nurses or paramedical personnel as patients.

**Patient Selection Criteria**
Poor patient selection is a central issue in many of the cases reviewed by our panels and seems to continue unabated. Some examples include an abdominoplasty and suction-assisted lipectomy on a 76-year-old woman and a forehead rhytidectomy on a 24-year-old man. Considering the ages of the patients in these cases, special consideration should have been given to the risk/benefit dynamics and/or unrealistic lifestyle changes expected by the patients.

In another case, a 66-year-old woman had multiple face lifts and bilateral upper and lower lid blepharoplasties over the previous 20 years. In 1990, a third face lift was performed. Postoperatively, the patient had excessive swelling, but no hematomas or seromas. The patient complained of difficulties with complete eye closure.
bilaterally and noted some weakness of the left upper lid. Her surgeon believed that the zygomatic branch of the seventh cranial nerve might have been damaged intraoperatively. He recommended a 6-week course of galvanic stimulation to improve the patient’s recovery rate. He then took a “tuck” in the patient’s lower lids to resolve complaints of excessive dryness. The surgeon noted what he perceived as “improvement” in the patient’s lower lids. However, the patient then moved elsewhere, underwent a full-thickness skin graft to the upper lids to relieve her ectropion, and filed a lawsuit. The panelists were supportive of the insured’s technique but believed that the patient’s course was predictable, with known complications. They were critical because the surgeon put himself at risk by choosing to do another lower lid blepharoplasty on the patient.

Although economic pressures and fierce competition for patients may be factors in selecting patients, failure to screen out individuals who are unsuitable candidates for plastic surgery is one of the most avoidable causes of malpractice claims for this specialty.

Economic Pressure
One of the most disturbing trends noted in recent panels is the tendency for some surgeons to use high-pressure sales tactics. In at least two cases it was clear that the surgeon had suggested additional procedures to correct problems different from those the patient had initially identified. Although nothing is inherently wrong with performing multiple procedures over an appropriate period, soliciting patients by encouraging additional new procedures creates the appearance of impropriety in the minds of jurors, whether justified or not. It also indicates an unsavory choice of priorities: economic consideration above surgical judgment. Defense of these cases is far more difficult if one of the allegations turns out to be, “The doctor talked me into it.”

Unexpected Costs
Patients often assume that although the expense of cosmetic surgery is their responsibility, their health insurance carrier will pay any costs incurred as a result of complications or unpredictable revisions. That is not always the case. Patients should be advised to discuss coverage issues with their health insurer before surgery to determine what is covered. One of the most frequent causes of claims in plastic surgery is the unexpected financial obligation the patient incurs when there is an unanticipated complication. Patients who have no insurance coverage should clearly understand—before surgery—that they are financially responsible if any postoperative problems arise.

Inadequate Training
In several cases procedures were performed despite the surgeon’s inadequate training in that particular modality. Regrettably, no training program is perfect. No residency fully prepares the emerging surgeon to cope with anything and everything that will cross his or her path. In aesthetic surgery, the problem is compounded because new modalities of treatment, new technologies, and new procedures arise all the time, requiring specialized and often hands-on training.

Whatever the competitive or economic pressures, aesthetic surgeons should weigh the risks versus the benefits of undertaking procedures for which a jury might fairly conclude they have insufficient training or experience. ■

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Digital Images Give New Dimension to Slide Presentations

One of the most important recent advances in computer technology is in the area of digital imaging. Virtually any type of image (e.g., photographs, illustrations, graphics) can be handled like any other computer file. The advancements in computer technology enable computer users to send images to other computers via modem, to store images on CD-ROM discs (up to 100 photographic slides or color negatives can be stored on a single CD-ROM disc), and to incorporate images into other software programs. Images may be downloaded from Plastic Surgery Online, CD-ROM discs containing royalty-free stock photographs, and other online services.

Digital images are produced through a variety of methods including scanning, video capture, and paint/drawing software programs. These files are usually large and require significant computer storage space.

To view or manipulate an image file, a viewer software program is required. Simple programs found within most online or office software packages allow the user to view and manipulate images. Software programs such as Microsoft Image (Microsoft Office package) and Adobe Photoshop offer the capability to manipulate digital images by enhancing or resizing images. The processed images can then be printed, incorporated into a presentation graphics program, or converted back into analog (photographic) format. Older computers may lack sufficient power or memory to efficiently process and store digital images.

The use of digital images in plastic surgery can be very rewarding and will give a new dimension to multimedia slide show presentations. It's definitely the future.

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It is indeed an honor to serve as your president, and it is with gratitude and enthusiasm that I embark on my 1996-97 term. I am extremely fortunate that my immediate predecessors have already set the stage for further development of some important new initiatives for aesthetic plastic surgery. The common thread running through all of these new activities—such as the ASAPS Candidate Program, the International Corresponding Participant Program, Plastic Surgery Online, the ASAPS Web page, the Cosmetic Plastic Surgery Referral Line, and the Clinical Journal of Aesthetic Surgery Quarterly—is the broadening of ASAPS' service to the plastic surgery community.

Certainly, the changes in our health care environment have made an impact on the educational mission of the Aesthetic Society. It is clear that the aesthetic component of plastic surgery practice will continue to increase in importance over the coming years. The maintenance of aesthetic plastic surgery as an area of medicine relatively independent of interference is something about which all plastic surgeons must be concerned. Yet the specter of managed care's involvement in purely aesthetic procedures has left many of us feeling that our most vital interests, as well as the interests of patients seeking quality aesthetic surgical care, are in jeopardy.

The Aesthetic Society is the strongest and clearest voice today representing the interests of aesthetic plastic surgery. To fulfill its responsibility to the specialty, ASAPS is in the process of "repositioning" itself. The ASAPS Candidate Program and the new International Corresponding Participant Program are both aimed at expanding the services provided by ASAPS to the plastic surgery community.

ASAPS educational programs have always been open to all plastic surgeons, but membership in ASAPS has been limited. Now, the Aesthetic Society is opening its doors to many more plastic surgeons who have significant interest in and commitment to continuing education in aesthetic surgery, as well as the high professional and ethical standards that are the hallmark of ASAPS membership.

Recent surveys conducted by the Aesthetic Society show that plastic surgeons believe membership in ASAPS will become increasingly important over the next 5 years. It is clear that the mission of ASAPS and the most critical needs of most plastic surgeons are rapidly converging. The leadership of ASAPS is determined to meet the challenge posed by this growing enthusiasm for the benefits of ASAPS membership.

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ASERF Launches Program to Aid Domestic Violence Victims

The Aesthetic Surgery Education and Research Foundation (ASERF) has implemented a new program to help plastic surgeons identify and aid patients who may be victims of domestic violence.

Marie Christensen, MD, chair of the ASERF Domestic Violence Committee, says the first objective of the new program is to recruit plastic surgeons as members of the National Coalition of Physicians Against Family Violence. “I strongly encourage membership in the coalition because it provides access to a wealth of information on domestic violence and the various programs that are available to abuse victims nationwide,” she says. A recent survey conducted by ASERF revealed that plastic surgeons are concerned about domestic violence issues, but need additional guidance on how to help patients whom they know or suspect have been physically abused.

According to the American Medical Association, one of every four American women is affected by domestic violence. “Recognizing signs of abuse is the responsibility of all of us in medicine—not just primary care physicians,” says Dr. Christensen. “As plastic surgeons, we are in a key position to help these individuals heal emotionally and physically.” For information on the ASERF domestic violence education program, call Dr. Christensen at 612/993-3304.

Newly Formed Electronic Communications Committee Sets Goals

An Electronic Communications Committee was recently implemented by ASAPS to oversee electronic communications within the Aesthetic Society. “This is an ad hoc committee that falls under the auspices of the Communications Commission,” says Mark L. Jewell, MD, committee chair. “Its primary goals are to enhance electronic communi-

Keep These Deadlines in Mind!

September 1 Deadline for ASAPS Membership Applications

The deadline to submit applications for Active ASAPS membership, which will be voted on by the membership during the 1997 Annual Meeting May 2-7 in New York, is September 1, 1996. For information, contact the ASAPS Central Office, 800/364-2147.

November 1 Deadline for 1997 Abstract Submissions

The deadline to submit abstracts for possible presentation during the 1997 ASAPS Annual Meeting scientific program is November 1, 1996. For additional information, contact Debi McCarty, ASAPS education coordinator, at 800/364-2147.
cations within the ASAPS membership and to assess the Aesthetic Society’s current and future use of computer technology for public education.” This includes determining how computers can be used most effectively to help aesthetic surgeons in the clinical setting and in managing their practices. “Of course, we’re also looking at additional, more innovative ways to incorporate computer technology into various ASAPS projects, such as electronic presentations and online services,” says Dr. Jewell.

The Electronic Communications Committee will make recommendations for computer courses, both beginning and advanced, that are offered during ASAPS annual meetings. The committee will also oversee the Society’s World Wide Web home page, which includes a search engine that enables the estimated 20 million Internet users to locate an ASAPS member in their geographic region. The page is already receiving more than 6000 “hits” per week.

Aesthetic Society members are now able to describe the services offered by their practices on a personal home page that can be linked to the ASAPS Web site. For more information, contact Linda Smessaert at the ASAPS Communications Office, 847/228-9274 or e-mail lindas@spaceworks.com.

ASAPS Guest Lecturers Visit Regional Societies

T. Roderick Hester, MD, who spoke to the Northwest Society of Plastic Surgeons, and Timothy A. Miller, MD, who gave a presentation to the Rocky Mountain Association of Plastic and Reconstructive Surgeons, are among several ASAPS members who have served as guest lecturers on behalf of the Aesthetic Society this year. Other ASAPS guest lecturers include John B. Tebbets, MD (Ivy Society of Plastic Surgeons), and Gustavo A. Colon, MD (Texas Society of Plastic Surgeons). Rod J. Rohrich, MD, is scheduled to speak to the California Society of Plastic Surgeons.

Guest lecturers are Aesthetic Society members who are invited to give presentations to regional societies in parts of North America. The Aesthetic Society assists by providing a $500 honorarium to defray the costs of the regional programs. For information about the ASAPS Guest Lecturer Program, contact the Central Office, Education Department, at 800/364-2147.

Special ASAPS Awards Presented During 1996 Annual Meeting

The recipients of awards for the best annual meeting presentations (1995, San Francisco) and for special service to the Aesthetic Society were honored during the 1996 annual meeting opening ceremonies and Presidential Dinner-Dance in Orlando. The following awards were presented:

• Marco Aurelio Faria-Correa, MD, Walter Scott Brown Award for Best Videotape, “Endoscopic Abdominoplasty Technique”
• Gustavo A. Colon, MD, Jerome L. Klingbeil Award for Teaching Excellence
• Felmont F. Eaves, III, MD, Sherrell J. Aston Award for the Best Scientific Presentation by a Resident/Candidate, “Endoscopic-Augmentation Mammaplasty and Abdominoplasty”
• Brad J. Jacobs, MD, Best Scientific Exhibit and Best Scientific Exhibit by a Plastic Surgery Resident, “Capsulomusculofascial Flap: A Treatment Option for Aesthetically Unacceptable Subglandular Saline Augmented Breasts”
• G. Patrick Maxwell, MD, In Chul Song Award for Exceptional Philanthropic Service by a Plastic Surgeon
• Gordon H. Sasaki, MD, Simon Fredricks Award for Best Panelist, “Facial Endoscopy”
• Jack Sheen, MD, Best Scientific Presentation, “Surgical Management of the Cocaine Nose”
• Carlos O. Uebel, MD, Raymond Vilain Award for the Best Presentation by a Corresponding Member or Foreign Physician, “Hair Restorations—What’s New?”

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Residents’ Corner

ASAPS Aesthetic Training Committee Offers New Service to Resident Training Programs

The ASAPS Aesthetic Training Committee (ATC) has a long and impressive track record of activities that support resident training in aesthetic surgery. Former ATC chairs William P. Graham, III, MD, and Lawrence L. Ketch, MD, have helped to develop the Aesthetic Society’s educational services to assist resident training programs in enhancing their aesthetic surgery component.

ASQ: Tell us about the new service developed by the ATC for resident training programs.

Dr. Graham: We have developed a program whereby an ATC member will, on request, visit any resident training program as an on-site advisor and evaluator of the aesthetic surgery educational component. Because each program has different strengths, these visits are intended to offer a highly individualized assessment of the program’s aesthetic surgery training.

ASQ: What prompted the creation of this new service?

Dr. Graham: It is largely the result of ideas expressed by resident program directors during meetings that have been arranged as “brainstorming” sessions. Dr. James L. Baker, Jr., immediate past president of ASAPS, really spearheaded this whole process by establishing a luncheon, held during the annual meetings, in which resident program directors are invited to discuss with the ATC their needs and ways to meet them in an open forum situation.

ASQ: What main ideas have emerged from these meetings?

Dr. Graham: We’ve been told that residents would really appreciate being able to obtain aesthetic surgery educational products and services at minimal costs, and we’ve responded with several measures. The annual instructional videotape developed as a part of the Aesthetic Society’s Video and Electronic Library series is now provided to resident training programs free of charge. The response to this has been very gratifying; we’ve received many letters from program directors thanking us for these tapes. We’ve also established resident discounts for most other ASAPS educational products.

ASQ: What was the original purpose of creating the ASAPS Aesthetic Training Committee?

Dr. Graham: About 10 years ago, the Aesthetic Society determined that attention needed to be directed specifically toward fellowship training in aesthetic surgery, and the ATC was formed to determine the best means of achieving this. After careful consideration, we determined that the most effective strategy would be to concentrate the best educational opportunities within established plastic surgery residency programs. We have since initiated a number of highly successful activities to assist these programs in enhancing their aesthetic surgery training component.

ASQ: What are some of these programs?

Dr. Graham: We were one of the first plastic surgery societies to offer residents the opportunity to attend our annual meeting scientific programs without paying a fee. We invite residents to attend the teaching courses free by serving as course monitors. Another highly successful endeavor, which has been in existence for 21 years, is the traveling professor program, which enables selected plastic surgeons to travel to resident training sites each year and give presentations on aesthetic surgery topics. During these visits, the surgeons also accompany the residents on patient rounds and provide instruction.

We have also begun to encourage ASAPS guest lecturers, who are usually invited by regional plastic surgery societies, to interact with resident training programs in the locale where they’ve been asked to speak. All of the programs and services that we’ve discussed reflect the Society’s commitment to providing quality education and career opportunities in aesthetic surgery.

For additional information on the new resident education enhancement service, contact Dr. Ketch at 303/270-8553, or Dr. Graham at 717/249-0100.
For patients with large pores, oily skin, or a tendency toward acne or milia, gel sunscreens, which usually have an alcohol base, are suggested. Examples include Pre-Sun Active Gel 30®, Shade 25® gel, or Solbar 30® gel. These products, however, can sometimes sting or irritate sensitive skin.

“Sport” sunscreens have the combined properties of moisturizing and gel suncreening agents. They tend to be less greasy than moisturizing formulas and less drying than gels. These agents are also waterproof and tend not to sting or burn the eyes. These sunscreening agents have a high degree of patient acceptance; however, in my experience, they do not provide the degree of protection that the moisturizing, high-SPF formulas do.

Finally, for those who are sensitive to chemical sun-screening agents, some sunscreens contain only the physical agents described above. An example is Ti Screen Natural Sunscreen®, which has an SPF of 16 and contains titanium dioxide.

Aesthetic Society News

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- Gaspar W. Anastasi, MD, had the special honor of receiving ASAPS’ Distinguished Service Award for his dedication and outstanding contributions to the Aesthetic Society. Dr. Anastasi has been an ASAPS member since 1975 and served as ASAPS President in 1988-89.

- Robert W. Bernard, MD, was the recipient of the Aesthetic Society’s first Leadership Award for Exemplary Leadership to the Subspecialty of Aesthetic Surgery. Dr. Bernard served as editor of Aesthetic Surgery Quarterly (ASQ) from 1991 to 1995 and currently is editor of the ASQ Clinical Journal.

- Robert Stanton, ASAPS executive director, was presented with the Award of Special Merit in recognition of his many years of exceptional service to the Aesthetic Society. Mr. Stanton is only the fifth person to receive this award since the Society’s inception.

In conjunction with the Aesthetic Society’s awards presentations, the American Association for Accreditation of Ambulatory Surgery Facilities presented Edward S. Truppan, MD, with its first Distinguished Service Award.

To Access the ASAPS Home Page on the Internet, use our new permanent Web site address:

http://surgery.org/

Find out how Aesthetic Society members can have their own personal home page linked to the ASAPS Web site. Call Linda Smessaert, marketing coordinator, at the Communications Office, 847/228-9274.