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NECK LIFTING PLATYSMA LATERAL REPOSITION AND DIGASTRIC CORSET

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ABSTRACT: After studying the anatomy of 10 fresh cadavers, we developed a technique for the treatment of the cervical area during face lifts. We called this technique PLATYSMA-SUSPENSION and PLATYSMA-PEXY rather than plication. This technique consists of suspending the free edge of the platysma muscle and fixing it to a resistant tissue close to the earlobe (Loré's fascia or temporo-parotid fascia). The anterior triangle of the neck was well defined and there was no need to undermine the platysma muscle because of a perfect sliding plane between the platysma and sternocleidomastoid muscles. This technique is both simple and effective. It generates long-lasting results, without the inconveniences or complications associated with other techniques.

MATERIALS AND METHODS: Ten fresh cadavers (ie, 20 hemifaces) were subjected to the proposed technique. They were photographed and filmed at all stages.

Ten more cadavers were dissected to study the submental area and we discovered that the best way to recreate the cervico mental angle and to rebuild the floor of the mouth is to use a digastric corset so that we could rebuild the retaining ligaments between the platysma/digastric and mylohyoid muscles.

More than 100 patients were operated by the senior author; they underwent platysma-suspension and platysma-pexy of the fascia described by Loré; associated in difficult necks (Knize 3 and 4 necks) with the digastric corset. The patients were followed-up for a minimum of 12 months.

CONCLUSION: PLATYSMA-SUSPENSION and PLATYSMA-PEXY in the fascia described by Loré is an extremely long-lasting and effective technique in cervical lifting. It generates impressive results, even in the most inferior portion of the neck. It redefines the entire anterior triangle, especially the sternocleidomastoid muscle and the mandibular contours. Furthermore, PLATYSMA-SUSPENSION minimizes the risk of nerve injury and hematoma by preventing deep and unnecessary dissections because the superficial cervical fascia has a perfect sliding plane between the platysma and the deepest structures of the neck.

In difficult necks, we do associate a digastric corset using a submental incision.

Pre-op botulinum toxin injections appears to be of great interest leaving the muscle at rest during the post-operative phase.

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FACIAL PALSY: LENGTHENING TEMPORALIS MYOPLASTY AND SMILE REANIMATION

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Since 1994, we have performed more than 180 smile reanimations using Lengthening Temporalis Myoplasty (LTM). This technique was inspired by the Gillies and McLaughlin techniques, but with some important advantages and differences.

Crucially, the temporalis tendon is directly inserted from the alar base to the corner of the mouth without interposition of fascia lata or tendon. This avoids the need to overcorrect at the time of surgery to counteract the inevitable stretching of the non-vascularised graft.

Furthermore, the contour deformity that follows the Gillies technique and its modifications is avoided because the muscle lengthen at the expense of the posterior portion by anterior rotation of the muscle. In addition, the line of pull is under the zygomatic, posterior to the plane of the cheek to reproduce the vector on the normal side and avoid contour deformities in the cheek. Finally, by passing directly through Bichat's fat pad to the nasolabial fold, a gliding plane is present which avoids the tethering sometimes seen with subcutaneous passage of the free flap or tendon.

The temporalis muscle is transferred in its totality so that it can switch away from its masticatory function to become a muscle for smile.

We were able to obtain successively a 'mandibular smile' (depending on the jaw movements), a voluntary 'temporal smile' thanks to the physical therapy independent to any jaw movement, and after 3 to 6 months a 'spontaneous smile' thanks to the brain's plasticity.

Although we always obtain a spontaneous smile with the lengthening temporalis myoplasty alone, thanks to the transfer of all the muscle, we were interested in visualizing the brain activity thanks to the functional MRI.

In 10 cases how had LTM alone we performed a functional MRI before surgery, 3 month after, and 6 month after and we could observe the way the brain plasticity works thanks to the transfer of all the muscle. We did notice the increasing of the smile area and the tendency to overlap the temporalis muscle area.

We did use the double lengthening temporalis myoplasty in 12 Moebius syndromas with a symmetric smile in one operative session.

The lengthening temporalis myoplasty is able to reanimate the smile in peripheral facial palsy sequelae and we can always obtain a spontaneous smile thanks to the brain plasticity and the speech therapy.

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FACIAL REJUVENATION AND FAT INJECTION SIMULTANEOUS FACELIFT AND FAT GRAFTING: COMBINED LIFTING AND FILLING FOR REJUVENATION OF THE AGING FACE

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The Aging Face and the Need for Fat Injections

Recognizing the components of the aging deformity of the face is essential to the planning of surgical procedures and to the recommendation of appropriate treatment. Careful analysis will reveal that most patient problems will fall into three broad categories:

- 1) aging and breakdown of the skin surface
- 2) facial sagging, skin redundancy, and loss of youthful facial contour
- 3) facial hollowing, wasting, atrophy and/or age related lipodystrophy.

Patients primarily concerned with surface aging of their face may not require formal open surgery and may achieve the type of improvement they desire through salon care and dermatologic surface treatments of the skin. Patients primarily concerned with facial sagging, skin excess, and loss of facial contour will achieve marginal, if any improvement however if surface treatments only are employed. They will require formal surgical lifts in which sagging tissue is repositioned and redundant tissue is excised if these problems are to be properly corrected and an attractive and natural appearing improvement is to be obtained.

Patients with significant facial atrophy and age-related hollowing and loss of facial fat will achieve suboptimal improvement from both surface treatments of facial skin and surgical lifts. Smoothing skin will not hide a drawn appearance due to loss of facial volume, and it is difficult to create natural

and attractive contours by lifting and repositioning tissues that have abnormally thinned and involuted with age. Restoring lost facial volume using fat injections is a powerful technique that is now acknowledged by most plastic surgeons and other physicians engaged in treating the aging face as the most important advance in aesthetic surgery in several decades or more. Properly performed, the addition of fat to areas of the face that have atrophied due to age or disease can produce a significant and sustained improvement in appearance unobtainable by other means.

4 BEAUTIFICATION: A CALIPER APPROACH TO GLOBAL FACIAL ENHANCEMENT

A Swift

Montreal, Quebec

The recent availability of safe volumizing fillers has provided cosmetic physicians with the tools necessary to contour facial features non-surgically with minimal discomfort and downtime.

This presentation focuses on outlining objective parameters necessary for creating a template to maximize each individual's facial beauty. The mathematical Golden Ratio Phi defines facial harmony and proportion, and can be found over the entire beautiful face, regardless of race or ethnicity.

Using specially designed calipers that calculate Phi proportions, individual facial beauty can be optimized naturally and consistently, non-surgically releasing every patient's beauty potential. The technique has proven to be safe, reliable, and reproducible.

5 FAT STEM CELLS

S Sliwin

Toronto, Ontario

Stem cells have the promise to change the paradigm of medicine. The presentation focused on practical aspects derived from our stem cell research of harvesting and separation including using a 3 mm pyramid cannula with hand or power suction only, no Waterjet, no Marcaine in the tumescence and using collagenase with a protease for separation of the stem cells rather than ultrasonic cavitation.

Fat grafting by Coleman centrifugation vs. Stem Cell assisted vs. PRP assisted techniques were discussed with the final answer still not in. A case was made to wash fat with crystalloids that contain 5% Dextrose to improve results. Fat storage for short times (less than a week) in 4° C with 5% Dextrose in crystalloids or longer by cryopreservation has been validated.

Finally cryopreservation of adipose derived stem cells as bioinsurance was reinforced.

6 HOW DOES NON-SURGICAL FACIAL REJUVENATION PLAY A ROLE IN PLASTIC SURGEONS PRACTICES

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GOALS/PURPOSE: Reversing the stigmata of aging through facial rejuvenation is increasing in popularity as it is now more accessible than ever with many different medical and non-medical professionals providing this service. The authors goals were to assess how non-surgical facial rejuvenation is integrated into plastic surgeons practices.

METHODS/TECHNIQUE: An electronic survey was emailed out to all members of the Canadian Society of Aesthetic Plastic Surgeons (CSAPS).

RESULTS/COMPLICATIONS: There was a response rate of 29% (47 out of 160 members). Of all respondents 83% performed neuromodulator injections and 89% used soft tissue fillers. The most common soft tissue filler was autologous fat followed by hyaluronic acid. Dermabrasion was the most frequent form of resurfacing in Canada with ultrasound being the least common. Sixty-five per cent sold skin care products and 29% sold herbal medications. Most surgeons (97.6%) felt that non surgical services were useful adjuncts to surgery and that was the motivating factor to use them.

CONCLUSION: With the ability to perform all types of facial rejuvenation surgery the surgeon is able to accurately provide the patient with all options for treatment. Plastic surgeons as a group tend to wait for procedures to be validated and are not lured by marketing strategies. Canadian plastic surgeons have made it clear that they will evolve at a pace that reflects safety and innovation.

7 ABDOMINOPLASTY WITH SCARPA'S FASCIA ADVANCEMENT FLAPS FOR IMPROVED WAIST DEFINITION

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It has been strongly suggested that the preservation of Scarpa's fascia during abdominoplasty leads to a decrease in postoperative complications. To date, the use of Scarpa's fascia to enhance cosmetic results has been limited as abdominoplasty techniques have advanced at a more modest pace in comparison to other cosmetic surgical procedures such as breast augmentation and facial rejuvenation. Continued evolution of abdominoplasty is vital to achieving lower complication rates and improved contouring in all patients. The inferomedial Scarpa's Fascia Advancement Abdominoplasty has been performed on over 150 patients since 2010. The purpose of this paper (with the inclusion of surgical video) is to illustrate the aesthetic benefits in improving waist definition and is supported by high patient satisfaction with complication rates in line with previous techniques.

This presentation is aimed at progressing the evolution of abdominoplasty to parallel facelifts which years ago moved to a multilayer approach for individualized care. Like facelift surgery and its partial procedure options, the use of Scarpa's fascia extends the ability to address an array of abdominal cosmetic concerns without increasing existing complication risks.

8 ASSESSING PATIENT SAFETY IN CANADIAN AMBULATORY SURGICAL FACILITIES RESULTS FROM THE 2010 CAAASF SURVEY

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PURPOSE: There is increasing interest regarding standards of care in facilities where procedures are performed outside of hospitals. Limited data exists to reflect the Canadian experience with office-based surgery. The Canadian Association for Accreditation of Ambulatory Surgical Facilities (CAAASF) is a national organization formed in 1990 to establish and maintain standards to ensure that surgical procedures done outside a public hospital are performed safely. The aim of this study is to determine how many procedures are performed annually in CAAASF member facilities, as well as to examine complication rates. In addition, the practice of several key patient safety interventions was studied.

METHODS: All 69 facilities accredited by the CAAASF were sent the survey. The survey focused on procedural data, complication rates and patient safety interventions.

RESULTS: The response rate was 89%. In total, 40,240 estimated procedures were performed. A total of 263 complications were reported (0.007%). With regard to patient safety interventions, 93% used antimicrobial prophylaxis, 100% used strategies to maintain normothermia, and 82% employed measures for venous thromboembolism prevention. Forty-four per cent of facilities permitted procedures to be performed on patients with obstructive sleep apnea and all facilities had established criteria for preoperative evaluation of these patients.

CONCLUSION: This is the first study to report on the Canadian experience with office-based surgery and to provide a perspective on current standards of care practiced in accredited Canadian ambulatory surgical facilities. Appropriate accreditation, well-established patient safety related standards of care and careful patient selection form the basis for safe and effective office-based surgery.

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