Aesthetic Plastic Surgery Symposium, Toronto, Ontario, April 17–18, 2009

Dr Walter Peters, Course Director, and the University of Toronto hosted the annual symposium and Dr WRN Lindsay, our founding plastic surgeon, attended. Dr Grady Core, Dr Mark Jewell and Dr Renate Saltz were our visiting professors in addition to local speakers.

This reporter noted many things of interest although it is not possible to mention them all or to attribute each to individuals.

There is a trend to analyse augmentation mammaplasty to attempt to better predict outcomes and the incidence of reoperations; for example, choosing textured implants for shaped devices and smooth implants for augmentation mastopexy.

Dr Saltz said shape was more important than the scar in mastopexy. Patients will accept the scar if the shape is good and long lasting and the superior pedicle or medial pedicle is useful. If the inferior pedicle is used it can be used to augment the upper pole.

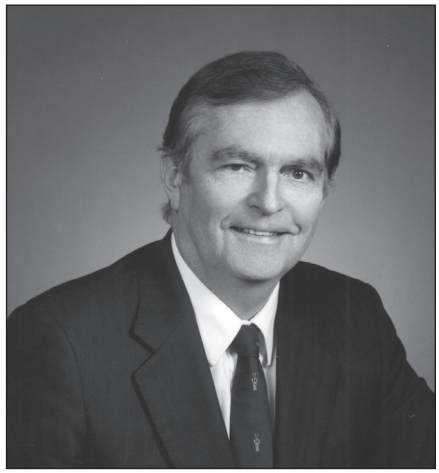
Dr Lista said surgery can be done faster with an improvement in quality noting that lessons can be learned from successful car manufacturers such as Toyota, the key being organization, repetition, staff training and planning. Surgical quality is now better in private clinics than in general hospitals. Sadly, general hospitals have no way to catch up because they are working on an old-fashioned model and show few signs of moving toward the future. Larger volumes mean better quality as surgery changes from the craft model, where every operation is different, to the assembly line idea, where similarities are stressed. This can be done while retaining patient personal contact and ultimately, results will speak for themselves. Ontario now spends 46% of tax revenue on health care. As revenues decrease there will be a squeeze, necessitating the adoption of new delivery models.

Surgical dissection and cautery using ultrasound is on the horizon but expensive. This allows dissection without heat or smoke.

Dr Core presented abdominal wall reconstructions advising the use of very wide mesh. It was noted that the complications of TRAM flaps seem to be under-reported by some.

Dr Peters presented a fascinating history of injectibles. These have been widely used around the world and despite cautions and in some jurisdictions illegal (eg, silicone injections), are still being done. 'Permanent fillers' need to approached with caution because some develop inflammatory reactions many years later and are difficult to treat. In the past 20 years, a new class of injectible fillers has been widely used in Ukraine, Russia and China – polyacrylamide hydrogel. History has a repeated itself. As of May 2006, the Chinese Food and Drug Administration has banned its use.

Drs Ford and Core presented midface rejuvenation using the lower eyelid approach by relocating lower lid fat and elevating the malar fat fad. This produces a good result without a preauricular incision, and has an acceptable recovery period.



Dr Core is pleased with the transaxillary augmentation under visualization and can insert up to a 300 mL low-profile gel implant this way. The simplest incision is likely the best.

Cosmetic medicine is a growth field, fuelled by lowering of insurance payments and family doctors diversifying. There was much discussion on the advantages and disadvantages of broadening one's practise to increase traffic flow through one's clinic. During the recession surgery seems down or postponed, but injectibles and medical aesthetics seem strong. Income sharing seems an important motivator and practice stabilizer and can lead to inequities, with nurses earning less than estheticians. A new initiative will remind the public that plastic surgeons are best qualified to do all cosmetic procedures for the safety and benefit of patients.

Dr Jewell thinks the minimal access cranial suspension facelift is a good procedure, but takes practice. The neck can be improved in some patients without much neck dissection and the three sutures are safe. The skin is released after the suture if irregularities are seen. The level of lift is vertical in front of the ear, which means a shorter scar behind the ear. It moves volume back up into the cheek. He likes size 0 PDS absorbable sutures.

Dr Saltz told us abdominoplasty can be improved by suction of the sides and back before abdominoplasty then limiting the dissection lateral to the rectus abdominus. Dissection of the flap superficially, preserving perforators, is of help. Obesity and combining operations increase the complication rate.

Dr Core said the key to endoscopic brow lift is fixation. The use of endoscopy seems to be waning likely due to the expense of equipment. He does midface lifts through the lower eyelid using a skin-muscle flap and elevates the malar fat pad, inserting the orbital fat pad into the naso-jugal groove. He also elevates the orbicularis oculi.

The meeting was well attended and a large turnout of nurses was noted.

John Taylor