



BSFPS Newsletter

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Editor's Introduction

The Editorial team welcomes you to the spring/summer edition of the newly titled BSFPS. Learn from the President, how our society is growing in numbers, his vision and developing his goal by delivering on the educational needs for our society.

Read Alwyn's editorial on the success of the facial plastics course held in March 2019 in Manchester. Do not worry if you missed that, see below the dates for the course next year. Expand your knowledge on facial reanimation surgery and how Peter Andrews is leading the way in the UK. How to manage the psychology of your facial plastic patients? Dr Victoria Carek explains all.

Follow our consultant panel discussion on a challenging case, see if you agree with all or none! Let's hope you do better in the voting stakes than our MPs have done in BREXIT! (sorry could not resist). In our trainee corner, learn how to become a facial plastic surgeon working in the NHS today, follow in the footsteps of newly appointed consultants. Read their fascinating journeys and dedication.

Let me know if there are topics you would like to cover or come and join us in the editorial team. Hope to see you all on 14th June in Birmingham, really exciting talks, not to be missed.

Sadie

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A Message from the President, Hesham Saleh

I welcome the ENT-UK and BSFPS members to our spring newsletter. I am very pleased with the growing number of BSFPS membership with a recent figure of 589, which spreads from consultants to students. We now have 194 consultants, 4 SAS's, 212 trainees, 137 students, 34 international members (mixed grades) and 8 allied professionals. In our recent council meeting it was agreed that we will continue working on new byelaws which will be presented in the next AGM, where we expect a good number of attendances. We aim to improve the structure of the council and have closer engagement from our members.

The second BSFPS Cadaveric Dissection Course took place on 4th and 5th of March 2019 at Manchester Medical School Cadaveric lab and proved to be a great success. A breadth of facial plastic procedures from rhinoplasty to blepharoplasty and facelift were covered. The course was filled well in advance with 16 dissectors sharing 8 heads. This was a dissection only course thus maximising the time for hands on dissection for delegates. The feedback has been excellent. We have noted that our delegates have asked for more dissection time and hence the next course in 2020 will be run over three days and will be on March 9/10/11. The format and venue remain the same. The course will be advertised by end of May and we encourage an early booking.

We are looking forward to the BSFPS annual meeting in Macdonald Burlington Hotel, Birmingham on the 14th June 2019. We have already registered a large number of attendees and places are still available for application on the ENT-UK website. We are particularly pleased to have received a considerable number of abstracts for the free papers section. The programme has been very well set up and will appeal to both novice and experienced surgeons. We are privileged to have two well-known international speakers in addition to an esteemed faculty from the UK. Registration is still open on the ENT-UK website.

BSFPS Official Course: Facial Plastics and Reconstructive Surgery Course

For the last two consecutive years, the BSFPS are proud to have successfully run their official facial plastics course held in the auspicious Manchester University Skills Centre. The course which runs over two days, is aimed for senior higher surgical trainees and consultants within Otolaryngology, Plastic surgery and Maxillofacial surgery. The course is renowned for delegates maximising their operating time on fresh frozen cadaveric specimens and covering a wide range of facial plastic procedures including open septorhinoplasty, tiplasty, otoplasty, facelift approaches, forehead lifts and upper and lower lid blepharoplasty techniques. The invited faculty span from local senior UK tutors to well renowned surgeons from abroad, both within our ENT speciality as well as Plastic and Oculoplastic surgical backgrounds. This course is unique in its kind as it ensures that the delegate achieves a comprehensive overview of common facial plastic techniques, demonstrated by tutors from different surgical backgrounds without necessitating the need of any lectures.

Upcoming Dates: 9, 10 and 11th March 2020

24 CPD Points

Anyone interested in applying for this course, which runs annually can do this through ENTUK or directly from the BSFPS website



The following is a short interview with Mr Alwyn D'Souza, who together with his BSFPS colleagues organised this course within our society.

1. Setting up this course was one of your legacies as the previous BSFPS president. Why did you feel it was so important for the BSFPS to run their own course?

It has always been my intention to bring facial plastics surgery into the ENT domain. I firmly believe, that as ENT and head and neck surgeons, we are well placed to provide facial plastics services which not only involves rhinoplasty, facial reconstructive surgery but also all the other aesthetic procedures on the face, scalp and neck. There were no training courses to support or act as a platform for the future generation in ENT to subspecialise in this area, hence the conception of this course.

2. How do you see the course developing in the future?

I see the course evolving in a number of different ways. It will in the future include teaching and training in non-surgical facial rejuvenation including botulinum toxins and fillers as well as laser treatments. The course may well take on a new shape with more basic concepts and procedures being taught in the first two days and more advanced procedures being taught over the subsequent two days for those wishing to do more extensive and technically

challenging procedures. I am in the process of developing a course manual which will serve as a practical guide to the course, and delegates can use it as a reference book with their own annotations made during their in the lab.

3. Do you have any official feedback that you can share with us from your delegates?

Yes of course the feedback has been very encouraging and comments included:

“Excellent course! thank you!

Fantastic course, well designed multidisciplinary team, great balance of practical + theory - Great venue”

I also had requests for more dissection time to be allocated. Having listened to these comments the course in 2020 will run over 3 days, providing more time for hands on training.



Faculty and Delegates from the 2019 Course

The Role of Facial Reanimation Surgery in Facial Plastics: An Interview with Mr Peter Andrews



1. Can you tell us a little about your professional background?

I was appointed as a Consultant ENT surgeon to the Royal National Throat Nose and Ear Hospital (RNTNEH) in 2005 which enabled me to pursue my interest in facial reanimation surgery. I had just completed my EAFPS Joseph fellowship in Amsterdam with Peter Lohuis and Gilbert Nolst Trenite which was centred around facial plastic reconstruction. My facial plastic surgery interest has always been focused on reconstruction and augmentation; whether it was around the nose, skull base or the face. My exposure to research started during my intercalated BSc at UCL medical school whereby I undertook a research project on nerve regeneration which resulted in a publication and it is from this that my academic career developed.

2. How did you develop an interest in facial nerve reanimation surgery?

My interest in facial reanimation surgery was inspired through training with Charles East and Peter Lohuis against a background of having an eye for aesthetic improvement. My interest developed further, when Professor Shak Saeed and myself joined forces in 2009 and formed the RNTNEH Facial Function clinic. Interestingly, the majority of our facial function patients had undergone significant lateral skull base surgeries and were not interested in prolonged free muscle transfer facial reanimation procedures. As a consequence I introduced a new dynamic facial reanimation technique; the Minimally Invasive Temporalis Transfer Technique (MIT3) which produced a dynamic smile almost immediately. This technique had not been performed before by an ENT surgeon in the UK and the operation takes less than 3 hours. I'm pleased to report we now perform over 15 of these procedures per year and I published my first 15 in Clinical Otolaryngology in 2015. The key to this procedure is that it does not

compromise the integrity of the facial nerve and works well in tandem with a facial nerve reconstructive technique which would be performed by my lateral skull base colleague.

3. Can you expand further on how the Minimally Invasive Temporals Transfer Technique (MIT3) is performed?

A 3 to 4 cm small incision in the nasolabial crease is performed to access the temporalis tendon. This incision allows blunt dissection through Bichat's fat pad and avoids the anteriorly placed parotid duct. By continuing the dissection posteriorly, ensuring that the buccinator is lateral and buccal mucosa is medial, the temporalis tendon can be released from its anteriomedial aspect of the coronoid process. The key is to utilise the entire tendon including its extension onto the ramus of the mandible. The temporalis tendon is supplied by two muscle bellies and it's imperative that this muscle is not overstretched as it can lead to hypofunction or a non functioning regional muscle transfer.



Primary anastomosis between the temporalis tendon and the orbicularis muscle, without the need of fascia extension grafts, is key. This can be achieved through mobilising the orbicularis muscle through the same nasolabial incision primarily through releasing incisions of this muscle and the modiolus. Next, the lower lip is mobilised enabling excursion of both the upper and lower lip. The temporalis tendon is subsequently sutured to the modiolus of the orbicularis oris muscle ensuring maximal lip excursion with 2/0 prolene. A 'trouser leg' fascia lata graft is tunnelled into the upper and lower lips through the nasolabial incision. They are secured in the lip midline with 3/0 pds via 2 separate mid lip incisions. The distal fascia lata graft is secured to the surface of the primary anastomosis with 3/0 pds. This enables the non-paralysed side to be pulled and creates an exaggerated smile on the reanimated side. This exaggeration settles with time.

The following are two examples using the MIT3 technique:

1. A right sided complete facial palsy of short onset (less than 18 months) secondary to cholesteatoma. The patient underwent a right MIT3 as well as a facial nerve interpositional grafting technique. Note the spontaneous dynamic smile; importantly in this case the MIT3 technique and the facial nerve repair work synergistically; the smile is powered by the MIT3 and the tone of the mid face is powered by the facial nerve surgery.



2. This lady had a complete facial palsy with a duration of over 2 years and underwent a MIT3 technique. The palsy had a duration of over 2 years which is a contraindication for concomitant facial nerve repair. Interestingly following 3 years of physiotherapy post surgery the brain re learns to smile using the 5th cranial nerve.



4. Together with your colleague Prof. S. Saeed, you run a monthly facial function clinic at the Royal National Throat, Nose and Ear Hospital. Can you explain how this service is run?

Our facial function clinic runs every 2 months as an MDT and comprises of a lateral skull base surgeon (Shak Saeed) and a facial plastic reconstructive surgeon as well as importantly a facial physiotherapist (Anne Holland) and speech and language therapist (Luke De Visser). As well as surgery and facial physiotherapy we offer an expanding Botox treatment service for facial synkinesis following Bells Palsy and for facial spasm. The facial function clinic has expanded and we now run a parallel service spear headed by my facial plastic reconstructive colleague; Prem Randhawa and Sherif Khalil my lateral skull base colleague.

5. If an Otolaryngologist with sub speciality interest in facial plastics wanted to get involved with facial reanimation surgery, what would your advice be?

My advice for a budding facial reanimation surgeon is to pursue an EAFPS fellowship which exposes you to all aspects of facial reanimation surgery. In the US facial reanimation surgeons have a very strong head and neck background and perform all aspects of facial reanimation surgery including facial nerve grafting, free muscle transfer techniques and temporalis transfer techniques and my advice is definitely spend time with our US colleagues.



The Role of a Clinical Psychologist in FPS Dr Victoria Carek

What role can a Clinical Psychologist take in the management of facial plastic surgery patients?

Clinical psychology input can be multi-faceted and multi-staged, there are key roles pre surgery, in preparing for surgery and perhaps following surgery. As is the case in all therapeutic encounters the relationship is key to the validity of the psychological assessment and outcome of any psychological intervention. Patients can understandably assume that the Clinical Psychologist's involvement is to act as a gatekeeper for surgery and this can lead to a narrative which omits key details they fear will impair the chance of surgery going ahead. However, the role is not to dissuade nor to persuade, as ultimately this is a medical decision. The psychologist can provide a space to explore the beliefs a patient holds related to their appearance, the surgery and their expectations. It is important to be open and honest about the role of psychological assessment, to be clear about any report or information which will be fed back and to who.

Pre surgery assessment

Research has indicated age, unrealistic expectations, relationship disturbances and pre-existing psychological pathology to be negative predictors of satisfaction (Konka, 2016). The Professional Standards for Cosmetic Surgery (2016) clearly state the necessity for 'consideration of vulnerabilities and psychological needs'. It is advised that surgery is avoided or deferred until a psychological assessment is undertaken in cases where there is a discrepancy in expectations, repeated procedures (particularly to one area), previous dissatisfaction or co-existing mental health issues.

There are clear roles in pre surgery assessment to provide an opportunity to explore the rationale and motivation underlying a request for surgery. The Clinical Psychologist can facilitate the consideration of a fuller picture of the person, considering their psychosocial context and factors that may be confounding the pursuit of surgical intervention. Psychological assessment can allow an opportunity to explore the patient's expectations of

surgery; their understanding of the procedure, knowledge of the risks, complications and their expected outcome. It is a chance to explore motivations, history and onset of the concern and current strategies for managing it. In the simplest terms it is an opportunity to ask 'why now' and 'what for' while in a supportive setting.

Preparing for Surgery

There can be a role for the Clinical Psychologist in offering sessions prior to surgery for example, in exploring behaviours and working with a patient to modify, reduce or stop behaviours which may prevent, delay or impact the success of surgery.

There is an important role in considering expectations, ensuring that the patient fully understands the procedure, the possible risks and complications and the likely recovery period. It is important to explore a patient's expectations of the outcome of surgery, considering the reality of this, how they would feel if the outcome was any different to their hope. Clinical Psychology can explore whether emotional and social concerns about facial appearance are a motivating factor, considering body image, confidence and relationship issues and the impact they expect surgery to have upon these. For some there is a strong belief that 'I will look better, and I will feel better'. It is noted that identifying the presence of Body Dysmorphic Disorder (BDD) in those seeking aesthetic surgery is challenging, particularly during a preoperative consultation. While screening tools can be utilised they are insufficient when used in isolation.

Following Surgery

Less frequently but on occasion there can be a role for the Clinical Psychologist following surgery with patients who experience adjustment difficulties, anxiety, low mood or even trauma symptoms in relation to the surgery.

Indirect Work

In addition to direct psychological input in the form of assessment or therapy, Clinical Psychologists can also provide indirect psychological input via supervision, reflective practice for professionals, consultation and training.

In summary, there are a number of ways in which Clinical Psychologists can meaningfully contribute to the management of facial plastic surgery patients, these can be direct patient contact or indirect work with professionals.

Panel Discussion: How to do it

We presented this difficult case to our expert panel for their thoughts/views on assessment and management. Many thanks to Mr Karkanevatos on sharing this interesting case and gaining patient consent for publication in this newsletter.

A 38 year old lady presented with predominantly left sided impairment of nasal breathing and complaints of an asymmetrical tip with residual tip deviation to the left. She has a history of two previous septorhinoplasties (both closed and open).



Professor Tim Woolford



The key in this challenging revision case is to perform a careful assessment, and to make a diagnosis of the anatomical abnormality causing the aesthetic or functional concern. The techniques required to address these issues can then be planned. Palpation is important to assess tip support and the soft tissue envelope which may limit the possible outcome. It is clear in this case that cartilage will be required for grafting, and likely that she will be cartilage depleted.

Assessment of the photographs reveals that on face view the nasal bones appear to be normal, there is a depression on the left in the mid third. There is asymmetry of the nasal tip, with fullness on the right and a significant depression on the left in the region of the soft triangle extending superiorly. Anatomically this is likely to be due to convexity of the right lateral crus, with a concavity of the left, which may have been over-resected. Deviation of the septum may be partially responsible for the right sided fullness, and this would be confirmed by rhinoscopy and palpation. The previous trans-columellar scar is visible.

The profile is generally aesthetic, though there is mid-third irregularity. Rotation & projection appear fine. The base view confirms the alar asymmetry and partial collapse on the left seen on front view. There is a septal deviation to the right. Her skin is of normal thickness, with early telangiectasia.

I would advise this patient that in my hands her surgery is best performed using an open approach, and consent for ear cartilage and the use of donor facia lata.

To summarise my likely technique based on the photographs.

Harvest of conchal cartilage using my standard lateral approach.

Skin & soft tissue envelope elevation (likely to be challenging) using the same trans-columellar incision. This is a case where I would use a rim incision on the left to allow suitable graft placement.

Approach the septum via a caudal & dorsal approach after separating the upper lateral cartilages – assuming one can be identified on the left. I would then perform a septoplasty, suturing the septum to the spine in the midline. If there was sufficient cartilage in the septum I would harvest cartilage.

Correction of dorsal irregularity - likely to be septal. Placement of single or double layer left spreader graft using septal or ear cartilage.

If there was a residual fullness of the right nasal tip due to convexity of the lateral crus I would address this using sutures, and possibly an overlay technique. I would then graft the left side using a pinna cartilage graft placed caudally to the lateral crus to support the soft triangle and alar. This will be technically difficult, and I think it likely that a strong convex non-anatomical

graft will be required to correct the alar collapse and overcome soft tissue scarring. The precise technique would depend upon the anatomy of the left lateral crus and would contour this graft with sutures. I would place a small columellar strut graft and an inter-domal suture.

Finally, I would place a single layer of donor fascia lata over the dorsum, and close the incisions, taking great care to evert the skin of the trans-columella incision.

Mr Ullas Raghavan



Assessment:

Face – it appears oval with slight asymmetry due to right cheek being more full. Nasolabial fold is deeper on right side. Skin appears normal, transcolumellar scar. Horizontal thirds and vertical fifths are equal.

Frontal view – Midline is straight even though there is an apparent 'C' shaped deviation to right with tip towards left. Upper third – left nasal bone is more slanting than right side. Mid third – Inverted V appearance more on left than right side. Left upper lateral is collapsed in and possibly detached from under surface of nasal bone.

Lower third – Right side has shallow alar groove with convex lateral crura. Left side the lateral crura is malpositioned superiorly creating a deep alar groove reaching the alar margin. Tip appears rounded. Columella appears retracted. The junction of ala with nasal sill is higher on left side. Alar base is wider than intercanthal distance.

Lateral and oblique views – the nasofrontal angle is approximately 130° . The radix appears in normal position at the supratarsal crease (but eye is closed) and of normal height. There is a small hump below the rhinion, possibly from dorsal graft or edge of upper laterals. Slight supratip depression. The columellar show is reduced, columellar breakpoint appears normal. The nasolabial angle is just over 90° . Tip projection is adequate considering the chin projection. Premaxilla appears under developed keeping upper lip behind lower lip. Deeper alar groove and alar margin higher on left with better columellar show as the alar margin is higher.

Basal view – Midline appears straight. Inverted V seen more pronounced on left side. Alar groove reaching and distorting left alar groove. Transcolumellar scar seen. Possible DNS to right. Right nostril appears normal and in normal direction. Left nostril appears flattened and in more horizontal direction. Left dome is in a higher position, probably due to malposition of left lateral crura.

Face down view – The lateral crural malposition is more noticeable and the convexity of right lateral crura is more noticeable. Interestingly, the inverted V is not well appreciated in this view.

Helicopter view – Midline dorsum can be seen to be straight. The deviated appearance is due to the collapsed left mid and lower third of nose.

Management plan

Needs revision open septorhinoplasty. If septal cartilage is not sufficient consider rib or conchal cartilage. Recreate straight septal support. Left nasal bone needs osteotomy and mobilised medially to get upper third straight. If required, osteotomy of right side too if upper third needs narrowing.

Mid third needs spreader graft thicker on left side to lift ULC. May still need overlay graft to mask the inverted V on left side. The hump needs correction depending on the cause.

Lower third – Left lateral crura must be repositioned to a lower position. For this the lateral crural must be dissected free, supported with turn in flap and lateral crural strut and repositioned in a pocket at a lower position to match the position of right lateral crura. Once the lateral crura is repositioned and straightened, this should correct the deep alar groove and the distortion of alar margin by the alar groove. The higher position of left alar margin and the higher position of junction of left ala and sill will be corrected too. The right lateral crura can be straightened and bulk reduced with a turn in flap. The columellar show can be increased with columellar strut of caudal septal extension graft. The rounded domes can be narrowed with sutures.

Any deficiency of lower lateral or upper lateral cartilage from previous surgery will need grafting with conchal cartilage or rib.

Mr Natarajan Balaji



Assessment:

Frontal view - The predominant deformity is in the left side of the tip and middle third. Nasal bony upper third is fine. The major deformity is weakness of the left lateral crus causing left alar pinching and collapse. Tip is tilted to the left side (same side as the weak lateral crus), typically happens due to unopposed relatively stronger contralateral lateral crus pushing the tip to the side of the deformity. This is on the proviso, that there is no issues with the caudal septum, both in position and strength (this can be assessed only by inspection and palpation of caudal septum) – in fact in this patient the caudal septum seems to be deviated slightly to the right side. The caudal border of the nasal bones and the frontal process are visible on the left side suggesting weakness of lateral “K” area and in drawing of the upper lateral at the internal valve. There is minimal dorsal deprojection as

well, due to weakness of mid dorsal septum and widening of upper laterals, more on the left side.

Profile Views - marked alar asymmetry seen on the left side with altered alar columellar relationship. Excess columellar show on the left side due to upward retraction of the left alar margin in keeping with damage to the lateral crus. There is slight over rotation of the tip complex in relation to the dorsum. Shows ear cartilage been harvested from right side.

Basal view - De projected nasal tip with a deviation to left and narrow, distorted nostril on left side. Loss of tip support is obvious. Shortened and thickened columella with a slight deviation of the caudal septum to right. Minor thickening in both alar regions at the incision lines, augmenting the functional issues of the external valve on the left side.

Aetio-pathology of this deformity

Damage to the left lower lateral cartilage with alar margin retraction and alar collapse causing functional external nasal valve obstruction. Lateral "K" area damage on the left side, with a weaker internal valve. Using Glasgow functional nasal wall subunit classification, she typically falls under lateral wall subunit 2 obstruction. There are also caudal septal issues with deviation to right. The left lateral crus is probably partly missing or fractured with tip distortion, ideal indication for lateral crural strut grafts.

Surgical Plan

Open approach, raise flaps, confirm the diagnosis. Separate the medial crura and identify the caudal septum, raise bilateral septal flaps. Harvest septal cartilage for both strut and spreaders. I would prefer a firm straight septal cartilage for reconstructing the lateral crus leaving an "L" strut. If not conchal bowl cartilage need to be harvested as well. Then get the caudal septum straightened and if necessary secure it to anterior spine. Next I would do a bilateral spreader grafts to stabilise the mid dorsum. Then dissect off the left weak and remnant lateral crus from the underlying alar mucosa after hydro dissection. Then the sequence of reconstructing the tip should always start from the medial crura. Both medial crural height should be first secured symmetrically and in the midline with a medial crural fixation suture with 5/0 PDS. Then left lateral crural strut grafts are secured under the weak lateral crus and secured in a slightly caudal position towards the alar margin with through and through 5/0 vicryl sutures. She may need bilateral strut grafts as well for balancing the tip.

Then consider inter domal sutures to bring the domes together if necessary. No bony work is needed. If any remnants of septal cartilage left, use it as a crushed graft to smoothen the dorsum. Close the flap and I will use an external splint despite no bony work. I give intraoperative antibiotic and steroid during induction.

Trainee Corner: Careers Advice for trainees in FPS

Babatunde Oremule is currently an ENT Registrar at Stepping Hill Hospital. He interviewed two BSFPS members (Kevin Kulendra & Okechukwu Okonkwo) who are at different stages in their careers, regarding careers advice and fellowships for the up and coming facial plastic surgeon...

Kevin Kulendra

Tell us a little about yourself?

I graduated from St. George's University London in 2004. I was torn between ENT and Plastic Surgery at the time of MTAS applications. However one ENT job lead to another and following SHO jobs at Charing Cross and RNTNE, I undertook a South Thames and Eastern Deanery LATs (the latter with Carl Philpott as his first SPR) prior to securing my NTN and starting my ENT HST in 2010 in the W.Midlands. During that time I had exposure to basic endonasal and open septorhinoplasty along with H&N skin cancer excision and local flap / nasal reconstruction at Worcester and Heartlands with Lance Hollis and Sharam Anari respectively. Prior to my CCT in 2016, I applied for both facial plastic and Rhinology/ skull base fellowships. I undertook my fellowships alongside my locum Consultant job at Oxford before securing my substantive post at W.Middlesex & Chelsea.

What fellowship(s) have you completed?

I completed an unfunded EAFPS fellowship between 2016 and 2018 as I was more interested in FPS than just rhinology alone. It is a competitive fellowship where you apply with other trainees from plastics, maxillofacial surgery and ENT from across Europe. There are a handful of funded (currently 16000 Euros) and unfunded posts each year. I completed it full time initially and then part-time over two years whilst working part-time (5 PA) as a consultant in Oxford before converting to a full time locum consultant. I completed 7 months with Alwyn D'Souza with exposure to H&N Skin Ca excision with local flap reconstruction in addition to a broad spread of facial plastic surgery in the NHS and private sectors including facelift, blepharoplasty, otoplasty, rhinoplasty (including revision with rib graft) and nonsurgical treatments, ie Botox, Filler and Laser treatments. More specific and complex revision rhinoplasty experience (including rib grafting) was gained with both Charles East and Julian Rowe-Jones for approximately 3 months each. I also spent one month over the summer holidays with Jonathan Sykes in Sacramento and Beverly Hills with further facial plastic experience including cleft surgery, endoscopic brow lift and fat transfer from the abdomen or thigh to the face. Normally 3 months of the 1 year fellowship is recommended to be undertaken abroad. I fitted the international component in across my oldest son's school holiday and was awarded the BRS travelling fellowship (£1500) for the international component to the fellowship as I had tailored one of my papers to rhinoplasty. Prior to starting my substantive job I spent just under 6 months with Shaz Ahmed in Birmingham

gaining advanced FESS and skull base surgical experience to help secure my substantive NHS post.

What motivated you to pursue a career in Rhinology/FPS?

I was interested in doing plastic surgery as a career before ENT higher surgical training, but as it happened one ENT job lead to another. During my ENT higher surgical training I became interested in rhinoplasty and facial plastic surgery. I liked the thought process behind reconstructing defects and the fact that one can get good patient satisfaction.

How did you develop your CV to be competitive and show sub-specialist interest in rhinology/FPS?

I tried to tailor my audit and research towards the speciality and present at facial plastics meetings. When preparing for the interview I'd recommend preparing for the basic questions, such as why you want to be a facial plastic surgeon, as they may not necessarily ask you about the details of your published papers. Think about why you are doing your fellowship and how it will help you define your consultant career. I had the opportunity to get involved with 3 book chapter publications including Scott Brown and Key Topics alongside completing a Rhinoplasty paper and chapters for a FPS Dissection manual, as I had the opportunity to learn from leaders in the field of facial plastic surgery.

What have you gained the most from your fellowship over and above what you learned/experienced during HST?

I gained further experience with H&N Skin Cancer management and Otoplasty in the NHS with first hand experience of aesthetic facial plastic non-surgical and surgical procedures in the private sector not seen in the NHS. There was flexibility and time to visit different facial plastic mentors and complete research papers and the opportunity to write a number of book chapters, which further advanced my understanding.

Do you have any advice for junior registrars wishing to pursue a career in Rhinology/FPS?

Make your interest known and seek experience locally. Attend and network at BSFPS and other international meetings. I would advise that you consider the funding streams for your fellowship, if unfunded then plan your finances in advance.

Okechukwu Okonkwo

Tell us a little about yourself?

I went to Newcastle university and completed my higher surgical training in the North West. In my student days I played American football for Great Britain and I am a Liverpool fan living in Manchester.

What fellowship(s) have you completed?

I completed the Training Interface Group fellowship (TIG) in Aesthetic and Reconstructive Surgery at Royal Surrey and Guy's Hospital between June 2018 and October 2018 supervised by Paul Johnson and David Roberts. My second fellowship is in anterior skull base and complex rhinology with Shaz Ahmed at the Queen Elizabeth hospital Birmingham October 2018 – September 2019.

What motivated you to pursue a career in Rhinology/FPS?

Mentors. There are certain people who I met throughout my career who took me under their wing and helped me develop. They gave me the confidence and opportunities to grow my skillset.

How did you develop your CV to be competitive and show sub-specialist interest in rhinology/FPS?

Do things that will demonstrate your commitment to the speciality; audit, research, courses and conferences. Show a keen interest with your local trainers. Observerships are another way of demonstrating an interest and widening your experience of surgical practice.

What have you gained the most from your fellowship over and above what you learned/experienced during HST?

A fellowship is the best thing that you can do. Your skills and knowledge grow exponentially with the breadth and volume of your surgical exposure. For example, at the QE it is fantastic to work in unit where rhinology is a dominant speciality. This has given me exposure to endoscopic management of sinonasal malignancy, complex rhinoplasty and neuroendoscopic surgery. While the TIG fellowship has given me the opportunity to work closely with allied specialties such as maxfax and oculoplastics and share knowledge with them as well as work with some of the leading names in rhinoplasty in the UK.

Do you have any advice for junior registrars wishing to pursue a career in Rhinology/FPS?

I would advise that they go and visit any units where they may be considering applying for fellowships as it provides an opportunity to assess whether the fellowship will meet your needs. Visiting also serves as a way to introduce yourself to units prior to any interviews and they will have more information to base their decision on. The best time to go would be around the end of ST6/start of ST7. If they are looking to go abroad, it would be advisable to visit two years ahead of time of applying.



**ENT UK British Society of Facial Plastic Surgery Annual Meeting
Macdonald Burlington Hotel, Birmingham, 14th June 2019**

The BSFPS Annual Meeting will be held on Friday 14th June 2019 at the Macdonald Burlington Hotel, Birmingham. This meeting will cover the breadth of facial plastic surgery with a focus on reconstruction, facial palsy and difficult rhinoplasty.

This popular meeting will delight delegates with information and debate around a number of topics in facial plastic surgery. Taking place during one day, this educational content will be delivered by renowned national and international speakers hailing from the ENT, plastic and maxillofacial surgery specialties. Guest speakers include Professor Yong Ju Jang Department of Otolaryngology, Asan Medical Centre, Korea and Dr Luis Laslatta, Department of Otorhinolaryngology, La Paz University Hospital, Spain.

For further information see website [here](#)



EAFPS 2019

Annual Meeting of the European
Academy of Facial Plastic Surgery

SAVE THE DATE

18 – 21 September 2019
Amsterdam, the Netherlands

eafpsamsterdam2019.org

