

BSFPSUK

BSFPS Newsletter

October 2018 | Issue 7 |



Sadie Khwaja, Editor

Daniela Bondin, Sub-Editor
Bilal Anwar, Sub-Editor



Editor's Introduction

Welcome to the Autumn/Winter edition of the BSFPS newsletter. As ever, a lot to read!

First is to welcome the new President Mr Hesham Saleh, and find out what he plans for the next couple of years.

As we had a bumper year of conferences, we have selected a number of key speakers from around the world to give you an international feel to this newsletter. Learn from the best on blepharoplasty, facial trauma and aesthetics. In the trainee section learn the pearls of performing a perfect Septoplasty!

I hope the variety of topics shows how our speciality is progressing and evolving! I hope you enjoy the newsletter.

See you all at the next BSFPS AGM.

Sadie

Inside This Issue

P2: A Message from the New President

P3: Babatunde Oremulé's report from the 3rd Annual Facial Plastic Surgery UK Meeting.

P4: An interview with Mr Fazil Apaydin.

P6: An interview with Mr. Gordon Soo

P8: An interview with Mr. Vishwas Vijayadev

P10: Talk Review: Septoplasty – getting it right first time!



A Message from the New President, Hashem Saleh

Progress is what shapes the medical profession and we must always aspire to continue building on what has been achieved. I am honoured to follow the steps of Tim Woolford and Alwyn D'Souza in establishing a strong society for facial plastic surgery. Very high standards have already been set and it is a great privilege for me to take the presidency at this stage.

Our annual meeting has proven its worth and has always been highly attended. We had a second highly successful cadaver dissection course in Manchester. The course covered the all-important facial procedures including facial flaps, blepharoplasty, rhinoplasty and facelift. Our next annual meeting will be held in Birmingham on the 14th of June 2019 and will be followed by two days of a cadaver dissection.

Facial plastic surgery has now become an integral part of many international otolaryngology meetings and we are pleased to have been involved in organising FPS programmes for BACO, ERS and CEORL-HNS. It is my plan to expand on these collaborations and work jointly with other associations to advance the educational opportunities for our members. I am particularly fortunate to have been voted as the next president of the European Academy of Facial Plastic Surgery (EAFPS) and can forge links between both sides.

The name of our society is a subject that has been deliberated for a while. It has been felt by many that FPS-UK has not captured attention and that a title, that parallels other societies in the UK, should be chosen. We looked at various suggestions and chose "The British Society of Facial Plastic Surgery" (BSFPS). We are pleased that the trustees of ENT-UK have approved the change of name. With the change of name and maturity of our society, it is timely to look into the structure of BSFPS. I plan to devise specific byelaws for BSFPS with the inclusion of wider election procedure for the council and more involvement from our membership.

Finally, I wish that you all have a fulfilling remainder of the year and look forward to seeing you in Birmingham.

3rd Annual Facial Plastic Surgery UK Meeting

Date: Friday 13th April 2018

Venue: Grand Connaught Rooms, London

Report by: Babatunde Oremulé, BSc(Hons), MBChB, MPH, MRCS (ENT), PG Cert

The third annual meeting of the British Society of Facial Plastic Surgery UK (BSFPS) was held at the Grand Connaught Rooms, London. The meeting was well attended by delegates from across the United Kingdom and featured leading experts in rhinoplasty, facial reconstruction, oculoplastics, otoplasty and non-surgical aesthetic procedures.

The meeting commenced with a welcoming address from the Chair of BSFPS UK, Mr Alwyn D'Souza. Simon Watts gave an overview of facial aesthetic and reconstructive surgery, highlighting new frontiers in tissue engineering, gene therapy, alloplastic technology and computer-assisted imaging. However, he urged us to be wary of creating "monstrous patient expectations" with the array of new technology coming onto the market. Anjana Haridas detailed her approach to upper and lower lid blepharoplasty and stressed the importance of asking patients about the 4 G's (Garlic, Ginger, Ginseng, Ginkgo) prior to surgery. Our visiting Austrian colleague, Herman Raunig, covered otoplasty with an excellent series of videos. Readers are reminded that they are available free of charge online by searching his name on www.youtube.com.

After morning refreshments, Alwyn D'Souza and Peter Andrews covered the pitfalls in facelift surgery and rhinoplasty respectively. This was followed by keynote talks from visiting facial plastic surgeons Gordon Soo (Hong Kong) and Choladis Sinrachtanant (Thailand) on the intricacies and surgical pearls considered in Asian blepharoplasty.

After lunch, delegates were then treated to a comprehensive talk on botulinum toxin and fillers. Dr Lydia Badia stressed the importance of addressing the correct layer for rejuvenating treatments, broadly speaking; topical products for the epidermis; fillers for the dermis; and botulinum toxin for muscles to address dynamic lines. Calum Farris gave a recap on facial nerve reanimation, in particular the advantages and disadvantages of 12-7 versus 5-7 nerve transfer.

Rhinoplasty techniques of the upper, middle and lower thirds and septum was covered by Hesham Saleh, Charles East, Natarajan Balaji and Tim Woolford. Key points to take away for trainees were that upper third surgery is essentially three steps; hump reduction, osteotomies and radix management; and an introduction to "Tripod Theory" when managing the nasal tip. Finally, an expert panel (Sharam Anari, Hesham Saleh, Natarajan Balaji) tackled controversies and confusions in rhinoplasty including use of spreader grafts, management of the infratip lobule and alar base reduction.

The Facial Plastic Surgery UK annual meeting is now an established meeting on the calendar for surgeons and trainees within this subspecialty. It continues to inspire academic growth

and improvements in standards. Please look out for details of the 2019 meeting to be published by ENT UK.

Interview with Mr Fazil Apaydin



Summary about Mr Fazil Apaydin

Mr Apaydin is a working Professor at the Department of Otorhinolaryngology of Ege University in Izmir. He is also the current President of the European Academy of Facial Plastic surgery, the UEMS representative of the academy in the UEMS-ENT committee, on the executive board of the Turkish Society of Facial Plastic Surgery and the International Board Certification for Facial Plastic and Reconstruction Surgery.

What is it that you mainly do?

In the last 20 years, working at Ege University, I have been committed to my subspecialty of Facial Plastics, mainly performing rhinoplasty, facial reconstruction following skin cancer removal, facial paralysis rehabilitation and aesthetic surgery.

How did you get into the facial plastics?

I've always had a passion for facial plastics and after becoming an associate Professor, I decided to develop this subspecialty interest. I did a short fellowship in Chicago, the United States, in this area and since then I have been a student of facial plastic surgery.

How did you build your practice and where do your patients come from?

It was rather difficult to build my practice in facial plastics. Initially, I had some resistance from colleagues to accept me performing facial plastic procedures as it was felt that this area was restricted to Plastic surgeons alone. There were also some obstacles to developing my practice by recruiting patients from my own city. Thankfully, my practice has gone from strength to strength and I am now well established and accepted and even receive referrals locally, and tertiary referrals from all over the country.

What is your impression of facial plastics in the UK and how it is progressing?

Looking back at our Facial Plastics history, two of the core founders of EAFPS were Tony Bull and Sir Harold Gilles (known as the 'father of plastic surgery', having pioneered a number of

reconstruction techniques), both of whom were British ENT Surgeons. Therefore, Britain is one of the founding countries of this subspecialty. I think there is a progressive and global development of facial plastics especially with knowledge and experience being shared through meetings such as EAFPS and BACO.

As you may operate on a different population of patients, do you think that your rhinoplasty technique differs to those working in the UK?

I predominately operate on Caucasian and west Asian noses. The same principals of rhinoplasty apply in any ethnicity, however there is a definite learning curve in performing this procedure. Those operating frequently, who study their post-operative cases - especially those that have not done so well - will ultimately become better surgeons.

What recommendation would you give to UK trainees interested in facial plastics?

There are numerous ENT surgeons in the UK who are exceptional surgeons, and I would encourage trainees to visit and operate with them. There is also a European Platform within EAFPS, and attending meetings and courses outside the UK will help to widen trainees experience further. As the President of EAFPS, we also encourage trainees to do a Fellowship. We deem our Fellows as being very precious, as in the long term they will take our torch and lead the subspecialty forward. Our fellowships are unique in that part of the fellowship is based in Europe and three months of the fellowship is based in America. The aesthetics aspect of facial plastics is more advanced in the US and fellows will therefore gain better experience by going there. I also welcome anyone who is interested in visiting my department and seeing our wonderful programme in Turkey to email me at fazil.apaydin@gmail.com.

How do you wish EAFPS to change?

There were a number of different changes which, as President, I wanted to bring to EAFPS. I am pleased to say that EAFPS is becoming more inclusive and the number of members has increased by 25% in the last 12 months. We have developed focus groups to develop facial plastics courses and are developing an assembly of live surgical broadcasts from all over Europe, and hopefully in the future, from all over the world. We have also developed a library of interesting surgical procedures for our members. We are evolving our social media aspect and encourage our members to watch this space, as we shall be broadcasting the changes very soon, including at the EAFPS Annual meeting in Regensburg on 12-15th September 2018.

Interview with Mr Gordon Soo



Can you tell us about yourself Mr. Soo?

I did my medical training at UCL and graduated in 1988. My training took me to various places including North London, Whipps Cross Hospital, Lister Hospital, Stevenage and as far as The Royal Leicester Hospital. After I attained my Fellowship, I had the itch to go back home to Brunei. I decided to stop at Hong Kong as a Visiting Lecturer at the Chinese University in Hong Kong as it was “the” place to be in Asia. The University was well funded and had all the latest equipment and as my experience was such a pleasant one, I decided to stay. Facial Plastics wasn't my original area as a practising ENT Consultant; this was actually otology. In 2007 I approached the Chair of the University to create a division of Facial Plastics, as this area was underdeveloped owing to the perception that facial plastics dealt with cosmesis alone. Due to my background and experience, I was subsequently appointed as the Founding Chief of Facial Plastics for the Chinese University. We are still currently the only division of Facial Plastics Surgery in Hong Kong. Through meetings and conferences, we decided to set up the Pan Asia Academy of Facial Plastics, spanning from Turkey in the west and Russia in the north, to Sri Lanka in the south and Australasia in the east. I am currently the Secretary of the Pan Asia Academy of Facial Plastics and Reconstructive Surgery. We organise annual meetings and work alongside the European Academy of Facial Plastics Surgery and other IFFPSS-recognised bodies. Our next meeting will be held in Yokohama, Japan, on 8-9th August 2018.

How did you get into performing Blepharoplasty, as its not typically a procedure that ENT surgeons would do?

It happened quite by chance. In 2003 I helped to run the ASEAN ENT Conference and met with Professor Choladis. I later visited his clinic in 2008 and watched his technique in double eye lid surgery. I was enthralled at how quickly he could perform this surgery, and at such a high standard. This visit really highlighted how many skilled surgeons there are in Asia. I joined his clinic and went to facial plastic missions around Thailand. It was this experience that trained me to perform blepharoplasty and double eye lid techniques.

What is double eyelid surgery and how is the surgery performed?

Many Asians have an absent or underdeveloped supra tarsal and/or epicanthal fold of the upper eyelid/s. The double eyelid surgery is an operation which seeks to create a natural looking upper eyelid crease which helps to give the appearance of larger looking, puffy eyes.

The procedure is performed under local anesthesia with minimal sedation. A full or partial incision is made in the upper eyelid where the patient wishes the crease to be. An elliptical incision of skin is taken and sutures are buried within the elevator muscles and attached to the subdermis of the upper eyelid skin strategically to form permanent double eyelids. Patients with no loose eyelid may avoid an incision and excision and the sutures are buried directly between the muscle and skin.

What are the risks/complications of the surgery?

The rate of complications are thankfully small. I consent for infection, asymmetry (which may be due to asymmetry of the orbicularis muscle), multiple creases, loss of lid crease over time, suture extrusion, lid retraction and damage to vision or eye movements (very rare).

How common is this procedure?

The double eye lid surgery is the commonest aesthetic eye surgery in Asia. It's very difficult to determine the exact figures of patients in Hong Kong having this surgery as patients are quite reserved, and some even travel abroad to have this procedure to avoid others finding out.

How do you think this operation has changed or will change?

The technique has adapted in ways where the incision has become smaller and smaller. I think that more ENT surgeons, especially those specialising in facial plastics, will get trained and perform this procedure.

How has your experience with rhinoplasty in Asia differ to your training in the UK?

There are a number of fundamental aesthetic and cultural differences between Asians and Europeans. Caucasian or Western noses typically have much more cartilage and therefore reconstruction using autologous grafts (the patients' own cartilage) is far commoner. Asians are typically cartilage depleted, and the cartilage is less robust. Moreover, most Asians would not be happy to have their rib excised. Aesthetically, many Asians would like their noses taller and bigger (as Asians typically have a lower radix and an under projected nose) with softer appearances and contours, which is another difference between Europeans and Asians having aesthetic and cosmetic rhinoplasty. Hence, implants such as Silicon or Goretex implants are often used. I understand that Silicon has fallen out of favour in the UK but we have good experience and outcomes with this material. Cadaveric implants are yet another material which can be found but different Asian countries have different legislations around their use. Patients are also seeking injectables to augment their nose. This is fast and cheap and hence an attractive option for many, but this is sometimes performed by individuals with insufficient training. Hence our surgical community are seeing more and more complications with their use in the form of infection, migration of product and granuloma formation depending upon the product injected. We often are required to remove and excise the capsule or tissue that forms, and re-fill defects using the patient's own fat, with fair to good results.

Finally, are there any visiting fellowships that trainees or consultants could apply to?

There are no formal fellowships available at present but our Pan Asia Academy of FPRS and ASEAN Academy of FPRS are looking into this. We welcome visitors to come to Thailand and Hong Kong, and to Professor Choladhis's clinic for 1-2 weeks as an observer.

Interview with Mr.Vishwas Vijayadev



Mr Vijayadev, can you tell us about yourself?

I currently work as the Clinical Associate Professor in Otolaryngology, Head and Neck surgery at Rajarajeswari Medical College and Hospital (RGUHS) in Bangalore with a consultant position at an advanced cosmetic centre in Bangalore. I have trained in a number of different institutes including in India, Canada and the United Kingdom. My specialist areas include facial trauma, periorbital aesthetics, facial paralysis, rhinoplasty, facial flaps, lipotransfer, cleft lip and palate and facial implants.

What would be your key messages for those wishing to do facial plastics in the UK?

Facial plastic surgery is a natural area for all ENT surgeons to get into. Many of our fine surgical skills are transferable into performing a number of different facial plastics techniques as well as our ability to use the microscope and endoscope. Moreover, the approaches of a number of operations are identical to those in facial plastics, for example parotid surgery and performing a facelift. I do however appreciate that there is a learning curve associated with facial plastics, especially with the cosmetic aspect of this subspecialty.

What specific skills are required to do Facial Trauma?

There are two aspects required in managing facial trauma: reconstruction of bony defects and the cosmetic/aesthetic aspect. I understand that the Maxillofacial team in the UK often deals with facial trauma, but in India we are also trained to reconstruct bony fractures using a number of different techniques including titanium plating, IMF wiring and screws. I think ENT can bring different skills to facial trauma including our experience with maxillary sinus surgeries, orbital decompressions and facial nerve repairs. I would encourage anyone interested in doing Facial plastics to manage Facial trauma and even train to manage bony defects.

How does Facial Plastic training within ENT in India differ to that in the UK?

Trainees in the UK have variable experience with facial plastics during their higher surgical training and are encouraged to do an interface or post-CCT fellowship. There are no current Facial Plastics Fellowships in India. Our association in India (FRCSI) is a member of the International Federation of Facial Plastics Surgery societies (IFFPSS), and we are in the process of creating a fellowship that will span across a number of different sites. Trainees will train for 3-month intervals with a number of different subspecialists, and also have the opportunity to visit other surgeons across different countries.

FRCSI also conducts a 5-day course to train junior consultants covering the entire domain of facial plastic and reconstructive surgery, held annually at an advanced cadaver lab in Bangalore. More details can be obtained from www.facialplasticsurgerycourses.com.

How do you think that Facial Plastic Surgery will evolve?

There are three aspects that I feel will shape facial plastics in the near future. I have noted that there is

a renewed interest within junior trainees to get involved and trained in facial plastics. There is also more expendable income for patients to spend money on better looks and therefore more patients wishing for these cosmetic procedures. I think that training will evolve to accommodate the renewed trainees' interest and the increase in patients' demand for such procedures. The third aspect is that technology in cosmetic surgery is also constantly evolving and our surgical approaches and techniques will change to help improve the outcomes and patients experience.

Talk Review: Septoplasty – getting it right first time!

By Maha Khan

Instructional Session by Mr Florian Bast

Bast, Florian^{1,2,3,4}; Hopkins, Claire⁵; Surda, Pavol⁵; Roberts, David⁵

Thursday 5th July 2018.

BACO: British Academic Conference in Otolaryngology, Manchester Convention Centre, Manchester, United Kingdom

1. ENT-UK, 2. German Society of Otorhinolaryngology, 3. The Rhinoplasty Society of Europe RSE, 4. The European Academy of Facial Plastic Surgery EAFPS, 5. Guy's and St Thomas' Hospital.

The aim of the BACO instructional sessions was to provide the delegate with a practical insight into value and disadvantages of the topic of concern. Mr Florian Bast, a Consultant at Guy's and St Thomas' hospital with a special interest in rhinology and facial plastic and reconstructive surgery presented an hour-long talk on septoplasty targeted at trainees, and provided both evidence-based and experiential advice on how to achieve the best possible outcomes in septal surgery.

Mr Bast was empathetic to the challenges trainees face when developing their skills in septoplasty, and certainly covered the most common challenges faced from patient selection, anatomy, assessment of the deformity, consent, pre-operative preparation, septal and turbinate surgery and some very useful pearls of wisdom.

Patient counseling and selection is often overlooked when teaching septoplasty, and I found this introductory component of the talk invaluable. Objective statistics presented such as a prevalence of deviated nasal septum affects approximately 80% of individuals but overall 30% of people complain of nasal obstruction, of whom only one-quarter have a deviated septum. Furthermore, a systematic review quoted demonstrated that 4% of 973 patients with CRS had contact neuralgia from a deviated septum which was unrelated to their facial pain. Since this talk I have quoted these statistics to carefully selected patients who have been advised that a deviated septum was the cause of their symptoms, but alternative pathologies were responsible. I have found this has helped them understand their pathology and appreciate treatment strategies well. Mr Bast also advised that studies report 38% of septoplasty patients suffer from postnasal drip, but that this persists in 95% following surgery, which I hope will also help me consent and counsel patients prior to surgery.

Mr Bast went on to revise relevant anatomy, and I really appreciated the role of the membranous support consisting of the anterior septum, membranous septum, medial lower lateral crus and the skin of the collumela after this. I valued the aspect on nasal valve anatomy and role in up to 51% of post-septoplasty nasal obstruction, as I often find this contributes to nasal obstruction in persistent cases.

Both anterior rhinoscopy and nasendoscopy are essential, as an anterior obstruction can be missed with an endoscope, and constriction can mask hyperplastic inferior turbinates, though may help in assessing the mucosal component of the obstruction. Photographs are useful in revision cases and anterior deformity obstruction, and imaging is usually only necessary in the presence of chronic rhinosinusitis or in medicolegal cases.

In the operating theatre, it was useful to learn that an infra-orbital nerve block can produce longer lasting anaesthesia than intra-operative morphine, and undertaking turbinate reduction prior to septal surgery allows the septal mucosal local anaesthesia longer to take effect. In patients with CRS, anterior turbinoplasty may be more effective than diathermy reduction, as epithelial regeneration associated with SMD reduced its efficacy. Anterior turbinoplasty is, however, associated with a 20% epistaxis rate and therefore nasal packing postoperatively may be warranted. In CRS the inferior turbinate bone is often hyperplastic also, but the delegate was advised to operate with reservation here to reduce risk of empty nose syndrome.

Florian Bast recommended the right-handed surgeon utilise a right-sided incision as a Killian speculum can cause pressure damage and long mucosal tears, and complete mobilisation of the septum through hydrodissection, joining superior and inferior mucoperichondrial tunnels and precise, minimal cartilage excision. Consider using loupes during septoplasty to improve precision. A warning against replacing crushed cartilage was stressed as this would inevitably become scar tissue and confers a higher risk of infection and complications. Larger, shaved pieces of cartilage should instead be replaced if necessary to avoid these unwanted effects.

Post-operatively, saline douches, antibiotic ointment and if turbinate reduction was undertaken, Otrivine are recommended. It is preferable for the operating surgeon to follow up the patient particularly if the recovery is complicated, but a second opinion may certainly be helpful in challenging cases.

Overall, this was an invaluable talk for a junior to middle-of-training surgeon, or anyone wanting a refresher or advice on refinement of practice. The experience of the surgeon together with the evidence presented was an invaluable feature, and I very quickly began to see the benefits of what I learnt from this talk within my operative and clinical practice.