

BSFPS NEWSLETTER

Editor's welcome



**Sadie Khwaja, Editor-in-Chief
BSFPS Newsletter**

Welcome to the 9th edition of the BSFPS newsletter. At the annual meeting we were told the society is growing with over 580 members. Read how the President of the society, Hesham Saleh, is restructuring the committee to include regional representatives. Read about the highlights of the BSFPS annual meeting in Birmingham and the EAFPS meeting in Amsterdam this year. Learn from Anne Dancey on how to fat graft and the benefits and risks. In the Juniors section, learn how to develop

and successfully choose a career in cleft surgery from Louisa Ferguson.

Finally thank you to Daniela Bondin and Bilal Anwar for being great and supportive associate editors from the start and welcome to the new team.

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Babatunde Oremulé



Antonia Tse



Rajeev Advani



Edward Noon

New editorial team

President's address



Hesham Saleh,
President BSFPS

The national faculty that included a mix of ENT surgeons, plastic surgeons and ophthalmologists were equally very informative. Prizes for best oral and poster presentation were awarded to the winners at the end of the programme.

The AGM was well attended, and the progress of BSFPS in its fifth year was presented. Importantly, the proposed bylaws for the society, introduction of changes in the council format and online elections were approved. We plan to announce elections for council and applications for regional representatives in the near future.

The next meeting will be held at the Hilton Glasgow Grosvenor on 27th March 2020.

“Importantly, the proposed bylaws for the society, introduction of changes in the council format and online elections were approved.”

I welcome our members to the BSFPS autumn newsletter. The 5th Annual Meeting of BSFPS was held in MacDonald Burlington Hotel, Birmingham on the 14th June 2019. We were very pleased with the high turn-out and the quality of the presentations.

Three themes on cleft surgery, facial re-animation and rhinoplasty comprised the main body of the meeting and were covered expertly by the faculty. The invited international speakers Yong Ju Jang from Seoul and Luis Lassaletta from Madrid gave outstanding talks on deformed noses and facial re-animation respectively.



Yong Ju Jang from Seoul at BSFPS 2019, Birmingham



Dr Luis Lassaletta from Madrid at BSFPS 2019, Birmingham

Structure of BSFPS approved at AGM

The council of the BSFPS consists of 7 executive officers, 10 national representatives and one AOT representative.

Executive officers

Immediate past president

President

President elect

Secretary

Treasurer

Media and newsletter officer

Other member

Regional representatives

1. North
2. Yorkshire
3. Midlands
4. East of England
5. South West
6. North Thames
7. South Thames
8. Wales
9. Scotland
10. Northern Ireland

The President, President-elect, and immediate past President will hold positions for two years. Other council members and regional representatives will hold their positions for three years with the possibility of one extendible period.

Report from the 2019 European Academy of Facial Plastic Surgeons annual meeting

MR BABATUNDE OREMULÉ

ST5 IN ORL-HEAD & NECK SURGERY, NORTH WEST DEANERY



The European Academy of Facial Plastic Surgeons (EAFPS) Annual Meeting 2019 was held in the deluxe settings of 'The Koepelkerk' at the Renaissance Amsterdam Hotel, 18-21st September 2019. This year's meeting was co-chaired by Dirk Jan Menger and Gilbert Nolst Trenité from the Netherlands and marked the start of a new term for the new EAFPS president Hesham Saleh from the United Kingdom. Around 400 delegates and faculty from over 40 countries were in attendance. Once again, the conference was well supported by technology, with a conference app available to download prior to arriving. EAFPS 2019 can also be proud of a strong social media presence.

After the welcome addresses, delegates were treated to a wonderful surprise recital at the opening ceremony. Welcome drinks and socialising followed. Sightseeing tours and a gala dinner formed the remainder of the social calendar.

The 4-day event comprehensively covered all aspects of facial plastic surgery. There were a multitude of quality talks on offer, however personal highlights were:

Day 1 – The inaugural EAFPS Juniors committee presentations on their aims and ambitions for increasing membership numbers, improving educational materials on offer from the society and building networking opportunities for trainees.

Day 2 – Kofi Boahene's (USA) multivector gracilis flap in facial reanimation. Andres Gantous (Canada) and Santdeep Paun (UK) presented opposing views on multi-ethnic rhinoplasty. Peter Hellings (Netherlands) described his use of 3D technology in rhinoplasty. Anil Joshi (UK) discussed reconstruction of skin defects using D-CELL tissue dermis – a material available in the NHS. Finally, Rui Xavier (Portugal) described his use of computational fluid dynamics (CFD) during pre-operative analysis of the nasal airway.



Delegates were treated to a surprise recital at the opening ceremony

Day 3 – Andrew Jacono (USA) – “What I learned after 2000 deep plane facelifts” was full of



MC Escher's bronze bust is the inspiration for the EAFPS logo

useful do's and don'ts. Alexander Donath covered injection rhinoplasty, its safety and efficacy. Regan Thomas' (USA) talk, 'The safety facelift', was illuminating. Samuel Mattine (UK) made sure to warn delegates that total nasal reconstruction should not be underestimated. This year the Tony Bull Award & Joseph Lecture was won and given by Roxana Cobo (Colombia). The new developments and innovations sessions boasted some excellent trainee presentations.

Day 4 – Scar revision and nasal trauma sessions were very informative. Finally, Hesham Saleh's (UK) talk on alar base reduction was instructive.

Members were also shown the bronze sculpture by Maurits Cornelis Escher, on which the EAFPS logo is based, and were told the story of how it was acquired by the society by Jan de Jong (Netherlands).

Trainees will be glad to know that the academy is considering giving out a prize for the best oral presentation given by a trainee for the first time at the next meeting. The prize will only be open

to members, but with membership for trainees currently only €50.00 per year, many may find it worthwhile. See [here](#) for more information on joining the society. The next meeting will be in Łódź, Poland between 17th to 20th September 2020.

Report from BSFPS 2019

MR BILAL ANWAR

LANCASHIRE TEACHING HOSPITALS TRUST

The BSFPS annual meeting was held at Macdonald Burlington Hotel, Birmingham on 14th June 2019. The meeting was hosted by Shahram Anari and was privileged to include an array of national and international speakers. Professor Yong Ju Jang reflected on his experience from Korea, including techniques in augmentation rhinoplasty within the Asian population. Dr Luis Lassaletta gave an insightful talk about his department's management of facial palsy and reanimation in La Paz University Hospital, and the key concepts learnt over the years.



The meeting once again had speakers from different speciality backgrounds including plastic surgeons. Anne Dancey discussed her experience with fat grafting and the long term effect on appearance compared to other techniques. Her fat transfer technique was outlined with possible pitfalls to look out for. Mark Lloyd talked passionately about his meticulous practice in pinna reconstruction and Tariq Ahmad discussed ways to deal with complex problems in cleft rhinoplasty and techniques he used to combat them. Richard Caesar, oculoplastic surgeon, shared his experience in blepharoplasty and eyelid reconstruction.

Louisa Ferguson talked on her pathway to becoming a cleft surgeon from an otolaryngology background, encouraging upcoming trainees to pursue their interests despite possible barriers. The rhinoplasty panel shared insightful lessons learnt from their past experiences with Alwyn D'Souza and Ullas Raghavan providing memorable experiences from difficult encounters with patients!

This year had a wide range of topics in the free paper session with best presentation being awarded to Mustafa Jaafar for his oral presentation entitled 'multilayered mucosal-xenograft transposition flap septal reconstruction - a new paradigm in septal perforation repair'. Best poster prize was awarded to Fergal Cadden for 'reconstruction of nasal defects using Melolabial flaps: a single surgeon experience'.

Interview with Professor Yong Ju Jang

MISS ANTONIA TSE AND MR RAJEEV ADVANI



Professor Yong Ju Jang MD, PhD
Department of Otolaryngology, Asan Medical Centre, Korea
jangyj@amc.seoul.kr

Professor Yong Ju Jang is a world-renowned rhinoplasty surgeon, specialising in the field of Asian rhinoplasty. The current President of Pan-Asian Academy of Facial Plastic and Reconstructive Surgery, he is also Professor at the Department of Otolaryngology at the Asan Medical Center in Seoul, Korea. His clinical and research interests lie in: rhinoplasty and septoplasty, reconstructive nose surgery, surgical management of empty nose syndrome, basic research on the pathogenesis of paranasal sinusitis, and the role of rhinovirus in sinusitis. Professor Jang is the principle author of 4 rhinoplasty books and has contributed to 8 book chapters in various rhinoplasty textbooks. He has published over 130 papers in peer reviewed international journals and has been invited as a guest speaker in over 100 conferences all over the world. We had the privilege of asking him a few questions at the BSFPS Annual Meeting in Birmingham this year.

What made you decide to sub-specialise in facial plastic surgery?

I started my teaching career in 1996 as a rhinologist. In my clinic, I came across many patients who came to me with a functional nasal problem combined with nasal deformities. It was then that I realised I needed to be able to perform rhinoplasty procedures for better management of these patients.

Who inspired you whilst you were training?

Unfortunately, I had no teacher in rhinoplasty during my training. I am kind of a self-taught rhinoplasty surgeon.

Were there any difficulties you came across during your years of training and how did you over come these?

I started rhinoplasty in 1997 by myself. There were many difficulties. Firstly, there were no good textbooks for Asian rhinoplasty, which is significantly different from Caucasian rhinoplasty. I taught rhinoplasty to myself by trial and error and reading many books and articles.

Would you be able to describe a technique in rhinology that you invented?

I have invented many rhinoplasty techniques during my career! These include: 1) Percutaneous root osteotomy for correction of bony nasal pyramid 2) The cutting and suture of L-strut for correction of a deviated nose is another technique I introduced and 3) I published a multilayer tip grafting technique for the first time.

Percutaneous root osteotomy:

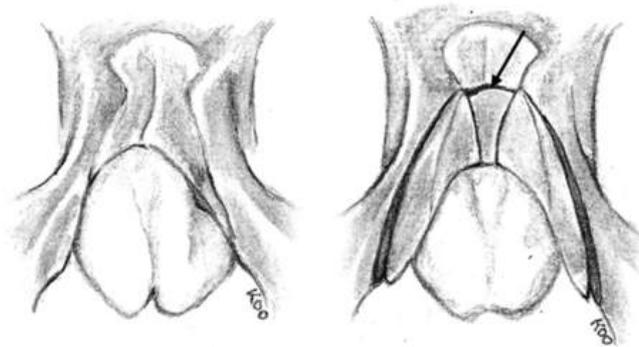


Figure 2. Percutaneous root osteotomy can mobilize the midline bony segment remaining after medial and lateral osteotomies. Black arrow indicates percutaneous root osteotomy line.



Figure 3. Percutaneous root osteotomy separates the nasal bony vault from the nasal process of the frontal bone.

(Yong Ju Jang et al. 2007)

L-strut technique:

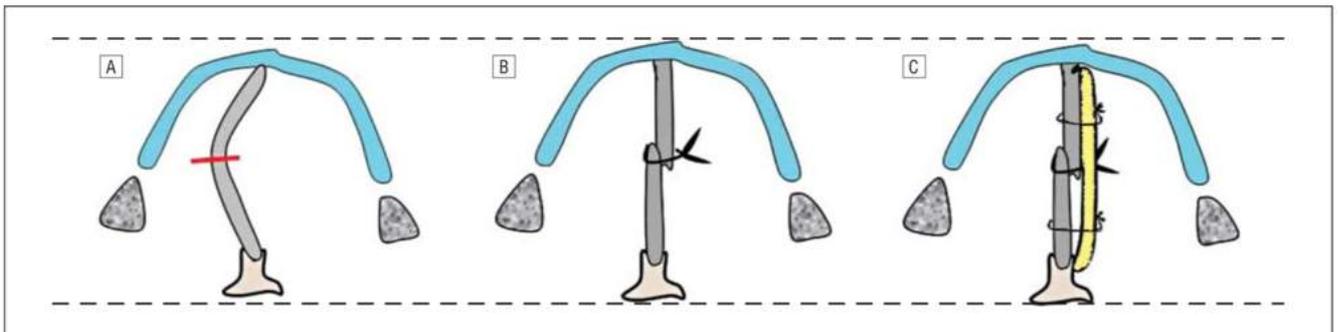


Figure 2. Illustration of the cutting and suture technique of the caudal L-strut. A, The deviated caudal L-strut was cut at the most curved portion in the caudocephalic direction. B, The excess portions of the upper and lower caudal strut were then laid over each other, and the overlapping cartilages were secured in place with 3 to 4 stitches using 5-0 polydioxanone sutures. The degree of cartilage overlap was adjusted such that the vertical height of the original caudal septum was not shortened as a result, which is illustrated as septal height. C, If the stability of the newly created caudal septum was questionable, a septal batten graft made from cartilage removed from the central part was placed for further support.

(Yong Ju Jang et al. 2009)

Multilayer tip grafting:



Figure 2. Placement of multilayer cartilage grafts. The more caudal layer was always shorter and narrower than the layer underneath. The leading edge of the caudal layer was shorter and narrower than the layer below it, and the leading edge of the more superficial layer was placed so that it was always higher than the height of the existing dome and the layer(s) beneath it.

(Yong Ju Jang et al. 2011)

What are the main differences in rhinoplasty techniques between Caucasian and Asian patients?

In rhinoplasty for Asians, the main concept is the augmentation. We have to build up the septum, tip and nasal dorsum in most cases. Also, a lot of graft material is required for Asian rhinoplasty. For this reason, the use of costal cartilage is a critically important procedure in Asian rhinoplasty.

Can you give 3 pieces of advice for trainees in facial plastic surgery?

My advice for a young facial plastic surgeon would be: 1) You have to be courageous 2) You have to love patients - provide meticulous surgical planning, execution and postoperative care 3) You have to push yourself to the level of perfection in surgical techniques by relentless effort and learning.

Do you offer any fellowships or courses?

I welcome short-term fellowships on septorhinoplasty and have trained more than 100 fellows from overseas. I also host an annual rhinoplasty course in Seoul. It is considered the best rhinoplasty teaching program in Asia and our 17th event will be in May 2020. Please visit www.ars2020.com for further information.

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Interview with Miss Anne Dancey

MR EDWARD NOON, ST6 ENT SPECIALTY REGISTRAR



Anne Dancey
Plastic and Reconstructive Surgeon

What is fat grafting?

Fat grafting is essentially recycling of fat and is the surgical process by which fat is transferred from one area of the body to another area. The surgical goal is to improve or augment the area where the fat is injected.

Where is fat most commonly taken from?

The best donor sites for fat taken seem to be the abdomen and hips, as the fat has increased lipogenic activity and larger cell size in comparison to other regions. However, fat can be taken from any area where the patient wishes to have fat removed.

Is there a significant donor site morbidity?

No, on the contrary, the patient considers liposuction as part of the benefits of the technique. Liposuction is a relatively low-risk procedure compared with other surgical interventions. Having said that, any procedure has associated risks and complications and these need to be fully explained to the patient. These include bruising and swelling, abnormal scarring (stretched, thin and hypertrophic/keloid port sites), asymmetry, loose skin, indentations, lumpiness, contour abnormality, discolouration, spider naevi, cellulite, DVT, PE, fat embolus, skin necrosis, numbness and delayed healing.

What are the advantages of fat grafting compared to the alternatives?

Since the 1990's, plastic surgeons have reliably used fat grafting to improve and enhance the cosmetic appearance of the face, breast, hands, feet, hips, and buttocks. However, more

recently, clinicians have documented the therapeutic benefits of fat grafting in the healing of wounds and scars, as well as fat's ability to repair damage following radiation treatment. Other forms of augmentation do not have any of these rejuvenation benefits.

Fat grafting is autologous, with no potential for foreign body reactions and there is a large total body donor site with potential cosmetic benefits to fat harvest. The fat injections are essentially scar-less with a needle nick as an entry point. There is a period of expected fat loss for the first 12 weeks following fat injections. Approximately 50% of the injected fat will be permanent. Once the fat has taken, it is stable and it has continued rejuvenating effects including improved vascularity, normalisation of pigmentation and increased cell turnover. The rejuvenating benefits seem to improve with time. The potential risks and complications are less than with fillers and it is cheaper in the long-term, as fillers need to be repeated every 6-9 months to maintain their effect.

What are the potential risks of the procedure?

The risks are actually minimal compared to other procedures, however, any procedure has associated risks and complications. These include fat necrosis (a lump palpable under the skin), fat loss, bruising, contour deformities, haematoma, infection, asymmetry and the need for revision surgery. Fat embolus resulting in blindness (if injected into blood vessels around the eye) or skin necrosis are rare but devastating side effects.

A recent review of large-volume fat injections into buttocks in the USA has shown an alarmingly high death rate associated with the procedure (1 in 3000). As a result, BAPRAS/BAAPS have recommended that it is no longer performed in the UK until we have more information. Fat embolus in the buttocks seems to be caused by fat injection within the gluteal muscle itself causing high pressure extravascular grafted fat to enter the circulation via tears in the large gluteal veins with subsequent embolisation to the heart and lungs. There were no cases in subcutaneous fat injection. In the face it is possible to cause blindness by inadvertently injecting fat into the retinal artery, which can embolise from the ophthalmic artery. Intracranial embolus has also been documented.

Could you talk us through how you do the procedure and the equipment required?

The process of fat grafting involves three steps:

1. extraction of the fat from the donor area with liposuction
2. decanting, centrifugation, and processing of the fat
3. re-injection of the purified fat into the area needing improvement

In the first step, fat is extracted from a donor area using liposuction techniques. In the face, this is best accomplished by manual methods using thin liposuction cannulas with small holes to produce a fine graft (Fig 1).



Figure 1

I prefer to hand harvest grafts using a 10 mL Leur lock syringe and a 3 mm multi-holed fat harvest cannula. This produces a finer graft, whereas larger holes retain lumpier fat which can block the fine cannulas used to inject the fat. The fat should be harvested in a low pressure system to improve fat viability. The ideal pressure is 18mmHg or 1-2 mL of space in a 10 mL syringe.

The fat is then processed with decanting or centrifugation to separate debris, excess fluid, and dead cells from the viable adipose fat cells. An alternate method is to wash the fat with a sterile saline solution. The debris that is discarded contains the fat cells which will likely not survive in the graft and they are detrimental to fat survival and fat volume estimation. For facial fat grafting, I allow the fat to stand and separate in the harvest syringe without being exposed to the air (Fig 2). After about 15 minute it separates into:

1. Bottom - fluid containing infiltration solution, blood and non-viable, broken cells.
2. Middle - viable fat.
3. Top - oil from fat lysis.



Figure 2



Figure 3

The fluid at the bottom can be discarded by simply injecting it out of the syringe. Keeping the 10 ml syringe upright ensures that the oil stays at the top. The fat to be injected is decanted into 1ml syringes via a luer lock to luer lock connector. The oil is left behind in the 10 ml syringe and discarded. In the final step, the fat is re-injected in small droplets throughout the subcutaneous tissue of the recipient area. This is to ensure good blood supply to every fat droplet so that the fat graft can survive. Specialised injection cannulas are used which are blunt and inject fat out of the side, to minimise the risk of injecting fat into a blood vessel (Fig 3). It is also possible to inject fat intradermally into a wrinkle using a blue hypodermic needle ('nano fat grafting') and this works well on peri-oral wrinkles and crow's feet.

Where did you learn how to do it?

In the UK, fat grafting is most commonly performed by plastic surgeons, as liposuction is a primary component of the procedure. Plastic Surgery trainees get comprehensive training in the standards of care for the liposuction procedure as part of our core training and should be fluent in managing complications associated with both fat injection and harvest. In addition to this I spent 3 months in Miami with Rodger Khouri who is one of the leaders in fat grafting and specialises in full breast reconstruction using fat grafting.

Has your practice with the technique changed now compared to when you began using it?

The more I use fat grafting, the more convinced I am of its rejuvenating and wound healing properties. I rarely perform facelifts without adding a fat graft. Even placing the graft near the incision seems to improve the healing and reduce swelling and overall recovery. In my hands, nano fat grafting into wrinkles is proving to be very promising with sustained wrinkle improvement, particularly in the peri-oral area. We are only just learning about the benefits of fat grafting and I am sure there will continue to be technological advancements making it an integral part of many treatments.

Trainees' corner

Interview with Miss Louisa Ferguson

Babatunde Oremule interviews Miss Louisa Ferguson, the only cleft surgeon in the UK with a background in ENT.

Can you tell us a little about yourself?

I completed my Core Surgical Training in London and then went on to the West of Scotland to complete my registrar training in ENT. It was at that point I decided I wanted to do cleft surgery and so I went off and completed a fellowship in paediatric airway surgery in Melbourne. I returned to the UK to complete a cleft lip and palate training interface group fellowship (TIG) in the South Thames cleft service. From there I went on to take a consultant post at the Evelina Children's Hospital, which covers South London and South East England for cleft lip and palate. I spend 60% of my time doing cleft lip and palate surgery and 40% doing paediatric airway surgery, which is what I was aiming for, so I am quite happy.



Why cleft lip and palate surgery?

I was always interested in deformity and facial aesthetics. As a core surgical trainee, I completed a taster week at Great Ormond Street with the cleft team. Then I started ENT training and slightly forgot about it. Later on, I visited the cleft team in the West of Scotland and sat in on their MDT. I started doing some of their lists which reinvigorated me. Part of the reason for that was that I really love rhinoplasty and facial plastics and I also love paediatric ENT. There was not really a nice gel of the two sub-speciality areas anywhere that I could see

apart from cleft surgery. It incorporated everything that I really liked about both. Adding the fact that it is a niche area, I was always quite interested in something a little bit different. You get to see patients from before they are even born and sometimes right up into their twenties. I also like working in a multi-disciplinary team and liaising with colleagues from other specialities and allied health professionals. All in all, cleft offers everything that I had hoped I would have in my consultant role.

Tell us about a normal working day for you

At my centre we work on a monthly rota due to the large area that we cover. I do something different every week of the month. Some weeks are quite cleft heavy and some are quite ENT heavy. We currently cover the whole of the East of England. Our team conduct outpatient clinics in Canterbury and Guildford amongst other places, but all the patients come to us for their surgeries. Normally I am away at least one day a week in a satellite outpatient clinic. Then I normally have an operating list for my cleft children three weeks out of four. One week in the month I do an adult operating list at Guy's. I also run a specialist speech clinic for children post-cleft repair or for non-cleft VPD once a month. I have a paediatric ENT clinic once a week, random operating lists and also ENT on calls. It takes a lot of organisation. I have not yet turned up in the wrong place, I am hoping I can keep it up!

What do you think your ENT background brings to cleft lip and palate surgery?

There are a lot of things, but the main thing is the assessment and management of the airway and sleep apnoea. Quite a proportion of the children have other airway abnormalities aside from cleft lip or palate. These include routine things like laryngomalacia and snoring to severe craniofacial abnormalities. Where my background has helped is that these children often end up flipping between ENT and cleft specialities to have individual problems addressed. So now I tend to see those children with dual airway pathology and help with airway assessment and management.

The second thing is nasal and septal surgery. The cleft surgeons are very skilled in cosmetic rhinoplasty and I have learnt a lot from them. I think that my ENT background helped with simple things such as nasendoscopy, which once I started doing most cleft surgeons where I work now incorporate into their practice. It has been nice to share those different backgrounds.

What challenges did you face in getting to where you are today?

I think the main challenge has been breaking into the cleft community which has previously been dominated by plastics and max-facs. I have had lots of support from colleagues from both specialities but making those initial contacts was a bit daunting. Certainly, when I went for the TIG fellowship, I was told to contact the previous fellows and people on the panel, however I did not know anyone. So that it was a bit of a challenge, although certainly not one that was insurmountable. One of the real challenges was getting my fellowships sorted before my CCT as it need to be completed within my training. Many deaneries are against pre-CCT

fellowships, but I wrote to the Dean of the West of Scotland and set out my ambitions and detailed my passion for cleft surgery. I found them to be very supportive.

Where do you see cleft services in the UK being in 10-years' time?

Cleft services have changed dramatically in the last 15 years, probably for the better. Especially in comparison to some other places in the world. We have tried to streamline services and have tried to make it very inclusive. I hope that will continue. I hope that we will have some more cleft ENT surgeons that will balance things out a bit more.

Finally, what do you recommend to any ENT trainees who would like to pursue a career path like yours?

I would recommend that they find a good mentor and to see as much as you can in your training. They are the two things because it is quite a big decision to put your hat in and say that you are committing to one thing. So do try and see some cleft surgery whilst you are in training and I am really happy if anyone wants to come down to St Thomas' and see what we do.

My journey into facial plastic surgery

Babatunde Oremule interviews Dr Darinka Hanga



Dr Darinka Hanga
Current EAFPS Fellow
Lienz, Austria

Tell us about your background?

I grew up in a family with deep roots in medicine. My grandparents were specialist doctors who lived in southern Hungary and helped people during the 1990's Yugoslavian war. As a result, since my childhood I understood how important it is to give people hope and an opportunity:

then to use those opportunities in a world full of challenges to make a difference in people's lives. The pressure to succeed has also been a privilege.

When I was 18 years old I applied for the numerous clausus Medical School, Heidelberg. I studied medicine as the youngest student at the university, and one of the first students on the HeiCuMed programme, which was based on the medical school program at Harvard Medical School. I did my training in ENT and Head & Neck Surgery at the University Hospital Heidelberg and finished my training in Düsseldorf at the University Hospital Skull Base Center. After I became a specialist, I started work as an Attending and faculty member in Austria, Lienz. My focus was on facial plastic surgery and I built up the facial plastic surgery department at Lienz Tyrol.

“The year(s) before fellowship are at least as important as the year of fellowship.”

Tell us something interesting about yourself

I started playing sport when I was five years old and became a professional handball player. The hard work and discipline in sport has taught me how to fight for myself and others, and also to persevere.

I was one of two foreign students when I moved to study in Heidelberg from Hungary. I learnt a different culture and studied in a new language. I learned that there is no success without hard work and studying hard. I learned that nothing is impossible.

I am an active member in a Foundation for educating talented children. The Foundation was formed to address the specific lack of education in art, music and history for children, who are talented but born into families without the opportunity to go to school. I love playing piano and making ceramic items with the children.

Why did you choose facial plastics as a career?

The face is the central defining part of our body used to express emotions, communicate and influence our interactions with one another. There are multiple facets of facial plastic surgery that interest me; injuries, facial irregularities, reconstructions and people who are concerned about aesthetic problems. It is a beautiful part of surgical medicine which is based on individuality. The artistic aspect of reconstructive and aesthetic surgeries appealed to me.

How did you prepare yourself to be successful in attaining the EAFPS fellowship?

In my early residency years I attended courses and conferences in addition to visiting surgeons. I found observerships were important steps in my learning curve. I chose hospitals where I was able to gain experience prior to my fellowship. The years before fellowship are at least as important as the year of fellowship so it is important to prepare. Try and do some facial plastic surgery prior to starting the fellowship to get the best out of it.

The European Academy of Facial Plastic Surgery offers brilliant surgeons and teachers who are motivational and inspirational. It has a board of education that is always willing and able to offer

support (Dr Frank Datema MD PhD and Dr. Peter Lohuis MD PhD) and answer questions about the fellowship application. The [website](#) is a useful source of information to find out more.

Tell us about the EAFPS fellowship.

The fellowship program provides an outstanding opportunity for the acquisition of specialised knowledge and skills. It comprises twelve months of surgical training in different centres with fellowship mentors who are recognised authorities the field. The Committee of Education and the EAFPS Executive Board select the best 2-3 candidates for funded fellowships each year.

During the year fellows see common and rare surgical procedures and scenarios. The case-mix includes procedures such as facelifts, all the way up to complex reconstructions. The fellow role involves working with mentors; doing clinical and surgical rounds, observing, assisting and performing procedures in theatre, and attending multi-disciplinary team meetings. The atmosphere and friendly teams in all of my rotations has also given me friends and colleagues for a lifetime.

I am doing the following rotations;

The Netherlands, Amsterdam, Utrecht: Dirk Jan Menger

Germany, Regensburg: Holger Gassner

New York City: Andrew Jacono

Baltimore Johns Hopkins University: Kofi Boahene

How do you hope to take the field forward and do you have a specific research interests?

I want to build up the facial plastic surgery department in Lienz and remain active member of the EAFPS. I have had the opportunity to learn from great surgeons in the academy, one day I hope to be a mentor and inspire the future generations. My research interests are in rhinoplasty and oculoplastics.

Finally, do you have any advice for trainees who would like to pursue a career in facial plastic surgery?

Work hard prior to your fellowship and ensure you have a good knowledge of anatomy. During your fellowship be hungry to learn. The fellowship is a once in a lifetime opportunity and it will be what you make of it.

So therefore, focus on the details - learn the instruments, the movements of the surgeons, watch their fingers and hands. Visualise surgery from different perspectives. Listen to the senior people and the good nurses - open your mind, eyes and ears. Watch your mentors doing surgery like you watch your favourite tennis player! There is no mentor who does not want to teach someone who is willing to learn. Work hard on your good days and work harder on your bad days. Above all, do not fear difficult moments because the best comes from them.