



FPS UK NEWS

FPS UK Newsletter - Issue 3, May 2016

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President's Message

Alwyn D'Souza, President FPS UK



Alwyn D'Souza,
President of FPS UK

Dear Colleagues and Friends,

I would like to thank you all, for the support and encouragement, I received to take over the leadership of FPS UK. It is my pleasure and honour to share some of my thoughts with you as the current President of FPS UK, having taken office on 4th February 2016.

First of all, the Council and I would like to thank our first and immediate past President Mr. Tim Woolford, for his tireless work, generous time and dedication, given to the society over the last 3 years. Tim was responsible for transforming FPS UK, which now has an established Council with definitive commitments, working to a framework, supported by a strong membership encompassing both Trainees and Consultants. The last two FPS UK meetings held in February 2015 and 2016, with excellent educational content were well attended, with delegates from ENT, as well as OMFS and General Plastic Surgery. FPS UK educational content was also a great success at the Glasgow BACO, and saw a further significant improvement in Liverpool last year. Congratulations, to all the FPS UK team under Tim's leadership.

It is now my responsibility to ensure progression of this great work moving towards our vision and goals. Having had keen interest in facial plastic surgery since my trainee days, it was obvious to me that, this great specialty within the ENT arena is generally restricted to Rhinoplasty surgery. This is very much reflected in considering Rhinology and Facial Plastic Surgery as a career choice for most. Surgical facial rejuvenation, and facial reconstructive surgery as such, is left to general plastic surgeons though OMFS are becoming prominent in the field in comparison to ENT. One of the main reasons for this as already alluded to, is the restricted concept of Rhinology/FPS. I clearly feel, to practice FPS comprehensively, one has to develop interest and a high level of competency in head and neck surgery including facial flap surgery in addition to rhinoplasty surgery. This skill set will serve well for the future facial plastic surgeon. This is evident if one looks at the American Academy of Facial Plastic Surgery (aafprs.org), a highly acclaimed society solely established by ENT surgeons in the 1950's, now leading the way in facial rejuvenation surgery including face transplant surgery. The European Academy of Facial Plastic Surgery (eafps.org) which I am allied to, is moving along a similar path. At the national level, I would like to see a transformation of our society to encompass all areas as mentioned already.

Additionally, non-surgical facial rejuvenation requires a special mention. This is the fastest growing branch of FPS, practiced with relatively little regulation, with variable training, by stakeholders in the aesthetic industry, which includes Beauticians, Aestheticians, Nurses, Dentists and Doctors from various specialties. In response to the Keogh report the Royal College of Surgeons has now come up with guidelines, following a long consultation process carried out by CSIC.

I suppose, the question is, why should we as ENT surgeons take this specialty seriously? The answer is simple. We as ENT and Head and Neck Surgeons are already trained to a significant degree in facial surgery, and further targeted training will give us the legitimacy to practice all aspects of the specialty. It is one of the fastest growing fields, with high public demand with significant financial rewards. Given the restrictions we all face within the NHS, I am sure one could reap both the professional and financial benefits for a better and brighter future. Additionally, we are beginning to see the effects of poor regulation, often the NHS is dealing with the

complications of poor practice in the private cosmetic sector. We in my opinion owe this service to the public at large in partnership with other surgical specialties.

I believe the key to improve this situation is targeted training both in aesthetic surgery, as well as non-surgical rejuvenation. FPS UK will assume an active role in providing this training. This will be carried out through high quality courses covering all aspects of facial rejuvenation under the auspices of FPS UK. These courses will rotate around UK, and will include trainers from various specialties, though primarily will be driven by ENT surgeons. These courses will include cadaveric dissections, video demonstrations as well as live demonstration of various techniques, in addition to didactic lectures. The annual meeting of the society will also continue to provide a high quality educational experience. FPS UK will also provide a mechanism for research activities pertaining to all aspects of FPS. Additionally I will be working closely with the European Academy of FPS (eafps.org), of which I have been a member and held various administrative positions for a while, to assist UK FPS surgeons to obtain European Board Certification in Facial Plastic Surgery (EBCFPRS). This certification ensures the highest international standard through a yearly examination currently held in London. This is the only validated examination, exclusively in facial plastic surgery and is administered in conjunction with American Board of Facial Plastic Surgery (abfprs.org).

At this juncture, I welcome your suggestions and ideas to be embedded into the framework to achieve the best training outcome by emailing me directly (ad'souza@nhs.net). Though it is an enormous task, it is achievable, as demonstrated by the late Mr Tony Bull who is the founder member of EAFPS, formerly known as the Joseph Society, which now leads the way in Facial Plastic Surgery in Europe.

Finally I would like to invite you all to attend the next meeting of the European academy 23-25th September, 2016 held in London. Please do visit www.eafpslondon.com for details.

My best wishes,

Alwyn D'Souza, President FPS UK

Consultant ENT/Facial Plastic Surgery,

University Hospital Lewisham, London.

Tony Bull: RIP

Mr Santdeep Paun

It is with much sadness that the UK and International Facial Plastic Surgery world mourns the passing of one its dearest and most respected colleagues. Mr Tony Bull as one of the founding fathers of the European Academy of Facial Plastic Surgery (EAFPS), then a group of like minded friends, laid the foundations to what is now a 1000-member strong community, enthused by his early vision. For many, myself included, he was the ultimate teacher and mentor that inspired careers in "Face Plastics" as he so endearingly referred to our subspecialty within Otolaryngology. A master surgeon, he was the voice of endonasal rhinoplasty and one of the major proponents of the Goldman technique of nasal tip surgery worldwide. Whilst rhinoplasty was undoubtedly his single largest passion, unknown to many, he was also an equally talented stapedectomy surgeon and seemed to switch effortlessly between the two skill sets.

An unequalled conversationalist, he shared his wisdom with his inimitably dry sense of wry wit and humour, instantly recognisable by the uniquely gravelly voice, a result of a long standing vocal fold paresis, that enthralled audiences in our shores and beyond. Indeed, there has been an outpouring of condolences from his friends, colleagues and admirers from the whole International Facial Plastic Surgery fraternity.

I had the fortuitous pleasure of being able to speak to him just a few weeks prior to his untimely death to tell him of a research prize being named after him by the European Academy. He agreed to be a guest of honour at the forthcoming EAFPS meeting to be held in London this September, where he was to present the inaugural prize in person to the recipient. Sadly, his demise came just prior to the accolade being advertised. The eponymous prizegiving ceremony will now be tinged with poignancy and his absence sorely missed.

Unforgettable as a pioneer, a leader, a visionary, an inspiration, a friend and mentor, he leaves behind a lasting legacy that will surely be remembered forever.

May he rest in peace.

Summary of the FPS UK Annual Meeting 2016

Mr Bilal Anwar & Miss Daniela Bondin



Miss Daniela Bondin and Mr Bilal Anwar

The FPS UK annual meeting was held at the Royal College of Surgeons of England, London on 4th February 2016 and built on the success of last year's inaugural event. This year's key note address was by Mr Peter Lohuis, a prominent facial plastic reconstructive surgeon based in the Netherlands. He gave an insightful talk on his model for a rhinoplasty surgeon's learning curve and progression through one's career and experience. He also spoke about rhinoplasty techniques including nasal valve surgery and his validated Utrecht questionnaire for outcome assessment in aesthetic rhinoplasty. His address was very well received. Mr Irfan Syed, Consultant Rhinologist, Lewisham and Greenwich NHS Trust commented that 'the talk was fantastic – the highlight of the day. It was interesting to follow his progress throughout his career and he was a great speaker.'



Mr Tim Woolford and Mr Peter Lohuis

The meeting opened with an update on proposed regulation and certification in cosmetic surgery from the Cosmetic Surgery Interspeciality Committee consultation by Mr Simon Withey, Consultant Plastic Surgeon, Royal Free Hospital. The audience were receptive to changes being introduced in order to improve the delivery, safety and regulation of cosmetic surgery. Mr James Barraclough, Consultant Otolaryngologist, Wolverhampton thought the session was 'informative regarding changes coming into play and now encouraged gaining certification for future practice.'

Dr. Sajjad Rajpar, Consultant Dermatologist, QE Hospital talked on facial skin rejuvenation options and non-surgical techniques such as chemical peels. Mr Ash Mosahebi, Consultant Plastic Surgeon, Royal Free Hospital followed with a review of the pre-operative assessment and face lifting techniques. Mr Saj Atallah, Consultant Oculoplastic Surgeon, Central Manchester University Hospitals presented on safe and effective techniques for upper and lower lid blepharoplasties.

The afternoon included a rhinoplasty forum on patient assessments, septoplasty in rhinoplasty, improving techniques in open rhinoplasty and endonasal rhinoplasty by various speakers including Mr Charles East and Mr Hesham Saleh. The session closed with a round table discussion on difficult rhinoplasty techniques. This also proved to be an educational end to the day's proceedings. Miss Sarah Little, Consultant Rhinologist, St Georges thought that 'the discussion about auto-spreader grafts and dehumping techniques was useful, especially Mr Charles East's insight regarding old fashioned mono bloc techniques of dehumping not being functionally beneficial as it displaces the anatomy of the upper lateral cartilages'.

The best poster prize on the day was awarded to Ms Ship Ojha for her work entitled 'Internal Nasal Valve: Validation of a grading system'. The meeting closed with the Annual General Meeting. The society has made great progress and established itself under the leadership of Mr Tim Woolford and there is much to look forward to as it goes from strength to strength under the new President, Mr Alwyn D'Souza.

The Private sector: An interview with Mr Douglas McGeorge on Blepharoplasty and Mid-Face Face Lift

Interviewed by Miss Daniela Bondin

Mr McGeorge is an eminent plastic surgeon in Cheshire in the NorthWest and talks about his views on blepharoplasty and mid-face facelift.

Can you tell us a little about your medical background?

I am a Consultant Plastic Surgeon working solely within the private sector for the last 13 years. I graduated from the Victoria University in Manchester and proceeded to do my House Officer jobs within this region. I moved around the country for my training working in Bristol, Leicestershire and London. I realised that I can go anywhere in the world for medicine so I spent some time in Cape Town, South Africa. Like many British fellows I worked in the Cardiac Surgery Unit at Groote Schuur Hospital. This was a fantastic opportunity to develop my surgical skills especially in trauma surgery. I came back to the UK and was offered a General Surgery Registrar post but I knew I only wanted to do Plastic Surgery so I chose to take a SHO post in this field instead. I have always known that I wanted to do Plastic surgery. I have quite good spatial awareness and instead of designing buildings I wanted to help people by 'redesigning' any deformities to exceptional standards. I finished my training in 1993 and returned to the North West and worked as a Consultant in the Countess of Chester Hospital. It was here that I helped to start up the Cosmetic Unit and Breast Reconstruction Service. After a decade working in the National Health Services (NHS), I decided to work solely in the private sector and have been doing so for the last 13 years.

What are the most common facial plastics procedures you do in the private sector?

In my experience the most common facial plastic procedure in the private sector are operations around the eye (blepharoplasty). The eyes play an important role within aesthetics. It is the first thing people look at and having 'tired' appearances around the eyes is what usually makes people look older. Blepharoplasty on its own has good results however I do recommend that a mid-face facelift is incorporated with a blepharoplasty to get maximal results.

Can you give us a brief overview of the population of people who have these procedures?

My facial plastics practice brings about variable patients ranging from very young adults to the elderly. For Blepharoplasty and mid-face facelifts the most common population are middle aged females.

What would you say is the minimum number of each procedure one needs to perform before becoming competent (learning curve)?

As a trainee I did hundreds of rhinoplasties, face lifts and blepharoplasty procedures on waiting list initiatives. However, as the NHS has evolved such opportunities have gone. I wouldn't want to commit on the number of operations needed for one to be deemed competent. However, we should be developing more robust mentoring

programmes, such that, for example, if someone has come through a period of training under me then I supervise them until that surgeon becomes confident in that procedure.

I feel that different procedures shouldn't be seen as a 'standard one-size-fits-all' operation. Rather a competent surgeon should have a full understanding of various techniques and have different skills within their armamentarium to be able to adapt a procedure depending on the patient. Once a surgeon has adapted to use different surgical tools and understand the surgical principles then I would deem them to be competent.

What would you advise future trainees who are interested in doing facial plastics in the private sector?

I recommend that trainees should initially define exactly what they want to do. There are many allied specialities that undertake facial plastic procedures. I don't advocate a learning curve on patients and I don't think attending a course alone is sufficient. I would recommend any surgeon wanting to evolve their practice to attend multiple theatre sessions in different centres and use trainers to help develop their skills further using for example mentoring systems or focused fellowships.

What are the advantages and disadvantages of working privately and for the NHS?

The NHS is a fantastic environment and I thoroughly enjoyed working within in. The variety of work and challenges were endless and I enjoyed training enthusiastic trainees. However, I did come across a lot of intrusion and dictatorship on how to manage patients. Eventually I wanted to have a bigger role in being involved in the decision making process, as well as to the day to day running of my own practice. This was the main reason why I left to work solely in the private sector. In my experience another advantage of working within the private sector has been the increase in the quality of time I spend with patients.

For the benefit of trainees can you briefly describe how you perform a lower lid blepharoplasty and mid face facelift?

There are a number of techniques and surgical variations when performing a blepharoplasty. The most common approach I adopt is a transcutaneous blepharoplasty approach. Pre-operatively, all patients are thoroughly evaluated by obtaining a detailed medical and ophthalmologic history and evaluation of the eye and periorbital area including skin quality, quantity and bony skeleton.

Intra-operatively I perform a subciliary incision and proceed to undermine the skin and orbicularis muscle. Leaving the pre tarsal orbicularis fibres intact, I proceed by dissecting along the orbital septum to the level of the orbital rim. I then divide the insertion of the septum to enter the peri-orbital fat space. It is here that I reposition or trim the fat. I proceed to fix the muscle vertically at the level of the canthus and then redrape the skin. I often incorporate a blepharoplasty with a mid-face facelift and therefore the mid-face is part of a lower blepharoplasty incision. The facelift doesn't treat anything other than the inside of a line drawn between the outer canthus and the corner of the mouth. So whenever I do lower blepharoplasties I am also addressing the full triangle in the centre of the face as this is where most of the facial ageing occurs. When combining both procedures I do ensure to stabilise the canthus and I would therefore recommend anyone wishing to do this procedure to be good at performing canthoplasties and canthoplexies.

Training Interface Group Reconstructive Cosmetic Surgery Fellowships

By Miss Daniela Bondin & Mr Bilal Anwar



Miss Daniela Bondin and Mr Bilal Anwar

Trainees have access to short fellowships within training known as Training Interface Group Fellowships. These fellowships vary in length of time and often cater for the trainees' needs. One such interface fellowship is the **Reconstructive Cosmetic Surgery Fellowship** which is a four month funded fellowship. This is an excellent opportunity for Trainees to develop their surgical skills in facial plastics including skin and reconstruction procedures, rhinoplasty techniques and non-NHS cosmetic procedures (Trainees may be asked to attend the private sector with their Trainer).

A number of training centres across the UK run this fellowship as listed below. Trainees have the opportunity to preference which training centre they wish to attend in their application process. The deadline for applications is biannually: Usually May and October of each year and applications are open approximately 4-6 weeks prior to these dates. Trainees can find these applications on the [Severn Deanery website](#).

As part of the application process, two references are required, one of which must be from the Trainee's local Training Programme Director. Interviews are held soon after. To support their application, Trainees are encouraged to show evidence of their commitment to this sub-speciality in their Curriculum Vitae. As each post varies to the Trainee's needs it is recommended that the Trainee has clear aims on what they want to do and achieve within this four month fellowship post.

Training Centres:

- Guys and St Thomas's, London and Royal Surrey County Hospitals
- Leeds Teaching Hospitals NHS Trust
- Royal Victoria Infirmary (Newcastle Hospitals NHS Foundation Trust)
- Portsmouth and Salisbury Hospitals
- University Hospital Birmingham NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- St Johns Hospital at Howden, Edinburgh
- University Hospitals of Leicester NHS Trust
- Nottingham University Hospitals NHS Trust
- Royal Marsden NHS Foundation Trust

TIG Fellowship: Plastic Reconstructive Surgery - My Experience

By Sadie khwaja, Consultant in Rhinology, Facial Plastics, Stepping Hill, University Hospital South Manchester



Sadie khwaja

In Aug 2011, I completed a four month fellowship in the Mersey Deanery. As it was my first fellowship, it was a fast learning curve in understanding the structure of the programme, it was complicated by my Educational Supervisor changing over. However the previous fellow was extremely helpful in guiding me through producing a bespoke timetable which incorporated what I wanted to gain in the fellowship.

As an ENT trainee, I was keen in exploring procedures such as blephroplasties, face lifts and other facial rejuvenating procedures.

I achieved this with attending oculoplastic theatre lists in the NHS. Maxillofacial lists in the NHS and private sector covering facial flaps for skin cancer through to facelifts.

I also attended private plastic surgery theatre and clinic sessions in the Cheshire region, gaining understanding in how to consult and explain the procedures to the patients as well as various facelift techniques.

My logbook was able to demonstrate this exposure with quantity however as most of the procedures were in the private sector, I was mainly an assistant doing part of the procedure.

I would recommend this fellowship as a great stepping stone into the world of aesthetic surgery but one has to be very focussed to gain the maximum benefit.

Mr Peter JFM Lohuis - Interview for FPS UK News

Interviewed by Mr Bilal Anwar & Miss Daniela Bondin

Mr Peter Lohuis was the keynote speaker at the FPS UK Annual Meeting 2016. Here he talks to the newsletter team about the rhinoplasty learning curve and a further insight into his work in Utrecht and Amsterdam.

Could you tell our readers about yourself?

I am currently working as a Head and Neck Surgeon in Amsterdam and as a Facial Plastic Reconstructive Surgeon in Utrecht.

I was trained at Utrecht University Hospital where I had great opportunities with excellent clinical exposure. I was able to build up my numbers in all procedures. I was motivated and conscientious in order to advance in my training. I did a fellowship after my residency through the EAFPS in facial plastic surgery for six months. I was one of the first in Europe to do the American Board Exams for the EAFPS. I then completed a further two year training fellowship in head and neck in the Netherlands Cancer Unit where I currently work. I also spent one year in Belgium to train in free flaps as at one point there was a lack of ENT surgeons doing them but after my training we were able to take this work on in our department independently. It broadened our spectrum and brought a further skill set – we became the standard. It was important for ENT and development in our hospital, but also in the Netherlands.

You talked about the rhinoplasty learning curve at the Annual Meeting, how did that develop?

It first came about when I began to think and talk about training and progression over the course of a surgical career. It developed from there really and when I created this model, I based it around a stock market model as I found it applicable to surgery too. I then looked in to it further in order to validate it.

I created a questionnaire to help define what kind of accelerators were important in a career and how these developed. I used a questionnaire completed by 50 world renowned rhinoplasty surgeons to get a reference point. I then also looked at other groups of surgeons such as residents and was able to contrast. This got me further interested as I could see a trend developing and realised that this was an accurate model that surgeons could relate to. Thereafter everything came along with it regarding experience and confidence as a surgeon and this is how the concept developed. I think people like it as they can identify with it. It also helped me on a personal level as I started seeing particular trends during my career and also made me aware of how I was developing. In my new rhinoplasty book I devoted the first chapter to this model!

What do you think the implications of the learning curve are for surgeons?

It gives you a better understanding of yourself as a surgeon and you are able to relate to it in terms of one's own reference point on the model. I think for the rhinoplasty surgeon it also helps you talk to patients. It is more

important to have awareness of the stage that you are at because it helps you address patient expectations. If they realise that you are in wave 3 (the wave of 'consistently good results'), it is easier to get the patient to accept you as their surgeon. If you know that you are in wave 3 then you have confidence in your ability that you can meet the patient's expectations. If you realise that you are in wave 1 then you know that you should not be too bold or promise things. The model helps me to know where I am and it can help other people. It gives the surgeon the confidence of being aware that they are in wave 3, but this awareness is important. What is dangerous is if you are in wave 1 (the wave of 'I like this kind of surgery') but have wave 3 confidence.

Wave 1	Surprise	: 'I like rhinoplasty'	: steepest wave
Wave 3	Conviction	: 'Consistently good and reliable results'	: longest, strongest wave
Wave 5	Hope	: 'I hope it stays like this'	: shortest, most shallow wave



Fig. 8. In a lifelong rhinoplasty learning curve (40-60 years) energy and commitment boosts ultimately take the form of five waves of a specific structure, followed by a sharp deterioration. On a smaller time scale (months to years), similar accelerations occur, dividing the waves of the largest degree into fractals. The 'career emotions' that relate to waves 1, 3 and 5 are, respectively: 'surprise', 'conviction', and 'hope'.

Reprinted with permission from Lohuis PJFM. *Advanced Caucasian and Mediterranean Rhinoplasty*. Amsterdam: Kugler Publications; 2014.

It also brings awareness to me about how my career is developing. There might be a time when I may have to do less head and neck and free flap work, and therefore I am developing teams so that I can supervise more. I may find that I operate less but take on more complex cases which fit in with the learning curve. For example, I take on complex cases in wave 5 (the wave of 'I hope it stays like this') that neighbouring hospitals may not be able to manage and I can use my experience and I feel that this is how my career path has evolved. I also realize that after wave 5 my abilities will decline.

How do you manage both sub-specialities?

It requires a lot of effort as I am involved in various cases that include facial nerve reconstruction, skin cancer, rhinoplasty and head & neck cancer, both in resection and reconstruction. I have to make sure that I keep fit and active. The development of the learning curve helped me realise that I may not be able to continue at the same intensity throughout my career. I make use of lecturing and teaching as it helps me to reflect on my practice. I keep focused on my research and publications and I feel like I have developed on all fronts to a good standard. I like the mixture of work and enjoy teaching. The diverse work has proved to be an advantage in that I have

found I often combine the different techniques learnt. This is my philosophy to help me work but it may not be for everyone and is personal to the surgeon.

Do you offer fellowships for trainees that may be interested?

I offer a twelve month fellowship that covers all aspects of my work – they join me in all my clinical and surgical commitments. My approach to training fellows is that I let them perform as much of the operation until they need my assistance. The advantage is that they get to start the operation and then they can proceed to develop the next surgical steps and what my techniques are. In a year there is a lot of learning opportunity.

I look for enthusiastic fellows that are willing to learn and preferably candidates that have already shown an interest in the fellowship beforehand.

I'm currently director of the fellowship for the EAFPS and now feel that I can relate better to training needs. In 2016 I will start to organise more learning opportunities by creating 3 month observerships across Europe. We have a lot of talented facial plastic surgeons who trainees can learn from. In this format there are advantages in that it is a shorter period and certification can allow it to complement further fellowships and also show commitment to the speciality.

I am an advocate of senior clinicians supporting the juniors in order to cherish education and development. We like to share our knowledge within this system and there is good energy. If this energy is broken then the system becomes broken. I see the problems there are in training, we are growing as a speciality and I am passionate about continuing development and progress in tomorrow's ENT surgeons.

Minerva Section

Hidradenoma Papilliferum of the Nasal Tip

A 48 year old woman presented with a five year history of an enlarging lesion on the tip of her nose. There was no associated tenderness, bleeding or nasal blockage but concern regarding cosmesis. On examination she had a smooth cystic lesion on the tip with normal findings on anterior rhinoscopy.

She underwent an ultrasound scan which confirmed an 11mm x 12.5mm predominantly cystic lesion with some vascularity on Doppler. MR Scan confirmed a round and well marginated lesion with no infiltrative features. It appeared within the subcutaneous tissues but intimate with the anterior border of the cartilaginous nasal septum with low signal on T1 and high signal on T2 weighted images.



She underwent an excision of this lesion using an open septorhinoplasty approach. Histology confirmed features in keeping with hidradenoma papilliferum. The patient had uneventful post-operative recovery with good cosmetic outcome.



Hidradenoma papilliferum is usually localised in the anogenital area and when found in any non-anogenital area may be referred to as 'ectopic'. It can occur on the face and scalp, where apocrine glands can be found, or over modified apocrine gland areas such as the eye lid and external ear canal.

HP can only be diagnosed by histopathological examination and is characterised by a well-circumscribed nonencapsulated cystic cavity with mostly papillary fronds or glandular patterns with columnar epithelial lining showing decapitation secretion on a basal layer of cuboidal basilar cells.

The prognosis for HP is good with local excision the treatment of choice. When located in such areas such as the nasal tip then surgical planning is imperative.

If you would like to contribute to the Minerva Section, please send your submission to Phillippa Chinery at email: phillippa@entuk.org.

Save the Date



Annual Meeting of the European Academy of facial Plastic Surgery (EAFPS)

The European Academy of Facial Plastic Surgery, co-chaired by Mr Alwyn D'Souza and Mr Santdeep Paun will be hosting their 39th Annual Meeting in London. This three day event will see expert speakers from all over the world, giving talks on a wide variety of facial plastics topics. Attendees can expect to hear about pertinent topics in the field including surgical and non-surgical rejuvenation, controversies in contemporary rhinoplasty surgery and skin cancer reconstruction.

If you would like to attend the event, please locate the website: www.eafpslondon.com.

Invitations for abstracts for both oral and poster presentations can also be submitted through the website. **The closing date for abstract submissions is Friday 17th June 2016.**

Date: 23rd - 25th September 2016

Venue: Grand Connaught Rooms, London

[Please click here for more information.](#)