

GLOBALPLAST

BERLIN '007

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BULLETIN

International Confederation for Plastic,
Reconstructive and Aesthetic Surgery

- 2 Note from the Editor

- 3 Minutes from the IPRAS EXCO Meeting in Mumbai, India

- 6 2004-2007 IPRAS Committees

- 7 50th Anniversary Mission Statement

- 9 Skin Deep Face Lift; A Global Perspective Panel

- 15 Plastic Surgery Meetings Around the World

- 18 IPRAS EXCO MeetingAgenda

GlobalPlast Editor:

Mutaz Habal, MD, FRCS
Tampa, FL

Managing Editor:

Jeffrey Dumont
IPRAS Executive Office
Hanover, NH

A Note from the Editor ...



The Long Hot Summer.

What a joy and a great last six months we had on the international arena. We had the joy of meeting more new friends and colleagues. We spent the summer visiting different geographic sites to teach and to learn more from the local groups and their different approaches as well as getting back to basics in patients care. We ended the year in Bangkok, Thailand, at the Oriental Society of Plastic and Aesthetic Surgery (OSAPS) meeting. We were back to the orient in India and had a great meeting in Mumbai. The hosts were super, the meeting was excellent, and the scientific conference was a great success. The local host groups were geared for facilitating the ease of presentation and communication between different groups around the globe. The last six months witnessed the birth yet of another multinational educational society. That is the Western Asia Society of Aesthetic Plastic Surgery (WASAPS). Their meeting was in Tehran with the Iranian Society of Plastic Surgery members as hosts. Speakers were gathered from Europe and the United States. The success was so good that the biannual nature of the meeting prompted the next to be hosted in Karachi by the Pakistan Society of Plastic Surgeons. In the United States, the American Society for Aesthetic Plastic Surgery (ASAPS) hosted an international symposium that was well attended and successful. The ASAPS meeting venue of New Orleans added an international flavor. The president of the society was in attendance and greeted most of the participants. The international flavor continued with a dedication of one day to international participation that was well attended and well regarded by the audience from all around the world.

After all, the goal of all the gatherings and congresses is the exchange of new ideas, the reiteration of old and existing procedures and sharing the views with different colleagues. It is the role of continuing education to stress the fact that plastic surgery is a dynamic specialty and it will always be so.

To all our colleagues and international delegates from around the globe, the International Society of Plastic Reconstructive and Aesthetic Surgery (IPRAS) will continue to be there for all the members and officers of our national societies. The mission of IPRAS is to help the beginners and give a hand to those who ask for help as the only global organization for plastic and aesthetic surgery. As we were asked before, membership in the organization is through the our national societies and there is not a category in the organization for individual membership. It is needed to bring the world of plastic surgery together.

Mutaz Habal, MD, FRCS
GlobalPlast Editor

All communications regarding GlobalPlast should be directed to:

Mutaz B. Habal, MD, FRCS
801 West Dr. Martin Luther King Jr. Blvd.
Tampa, FL 33603-3301, USA
mbhabal@gte.net

The meeting was called to order in the Conference Room of the Taj Mahal Hotel at 9:35 am.

Dr. Eisenmann-Klein declared a quorum present.

Members Present: Drs. Al-Numairy, Berrocal, Chen, Daver, Eisenmann-Klein, Habal, Hoehn, Lari, Lee, Morrison, Nicolai, Olbourne, Topaz, and Zaki.

Members Excused: Drs. Berger, Bruck, Drzewiecki, Erol, Garcia-Velasco, Goes, Harii, Hinderer, Iverson, Kirschbaum, Lamont, Mazzola, Mottura, Olbrisch, Pallua, and Salyer.

Dr. Hoehn presented the current medical condition and treatment protocols which Dr. Hinderer was undergoing in Boston for the recurrence of the squamous cell cancer of the lung. He was 2 weeks into a 5-week course of Proton-Beam irradiation. His address in Boston was distributed.

MINUTES

The Minutes of the EXCO meeting, August 28, 2004, Houston, TX, had been previously circulated. They were approved as presented.

REPORT OF THE GENERAL SECRETARY

1. Secretariat Contract

The Contract for the Secretariat had been modified to 1) more accurately reflect the services that were being provided to IPRAS, and 2) to change the anniversary of the contract to December 31 of each year. A revised contract has been executed by Dr. Hoehn and Ms. Foss.

The position of Executive Webmaster, previously authorized in Houston, had been extended to Jeff Dumont, a member of Conference Management Associates, and it was accepted at the payment rate of \$5,000.00 USD per year, payable in quarterly installments.

ADDRESS LISTS

1. EXCO

The current address list was circulated and updated where appropriate. The importance of maintaining accurate contact information with the General Secretary and the Secretariat was emphasized.

2. Representation

Dr. Hoehn reported on his activities, which included and will include the Gulf Coast Conference, which was held in Oman under the auspices of Dr. C. Thomas; the Asian-Pacific Section in Mumbai; and the conjoined PanAfrican-PanArab Section meeting in Marrakech, Morocco. His plan to attend each of the Section meetings will be complete with attendance at the ESPRAS.

NATIONAL DELEGATES CONTACT INFORMATION

A plea was made to try and reach as many of the National Delegates as possible. The use of the internet to communicate information to National Delegates and thus to the National Societies is becoming easier each year. The Secretaries General of the 5 Sections were asked to facilitate this task.

MEMBERSHIP ISSUES

Romania

IPRAS continues to be on the alert for shifts in the primary national plastic surgery society representing the country to IPRAS. Dr. Nicolai reviewed the issues and the correspondence that he had had with a Dr. Lascar of Romania. It seems that the Romanian Society has reorganized itself into the Romanian Association. Further information regarding this reorganization will be requested.

Macedonia

A concern was expressed by the Hellenic Society regarding the status of Macedonia as a recognized country and a member of IPRAS. Dr. Nicolai, General Secretary of ESPRAS, was the recipient of several let-

ters. The issues have not been completely sorted out as yet. It should be understood that the emergence of Macedonia followed from the dissolution of the former Yugoslavia. IPRAS has admitted each of the countries, which have similarly evolved.

Bosnia-Herzegovina

Bosnia-Herzegovina has formed a society as well. We have this information from M. Colic but have had no formal contact from the society.

Bahrain

Dr. Tariq Aziz has made formal application through the offices of the PanArab Association but this information has not been received in the Secretariat. This seems to be a communication problem which is solvable. Their application should be available soon for action by the EXCO.

Cyprus

Dr. Hoehn has received further communication from both parties in the Cyprus – North Cyprus issue. North Cyprus has applied for membership but has not fulfilled the longevity criterion. A copy of the 2004 Annual Meeting Program was forwarded for information and was filed. Some commentary has been made that cooperation and consolidation may be forthcoming.

Saudi Arabia

No communication has been established with the Saudi Arabian Association. However, Dr. Eed is attending the Mumbai meeting and will be approached.

Estonia

A communication has been received requesting contacts in Estonia. No National Delegate has been established and reported to the Secretariat. It is hoped that an official of their society will be attending the ESPRAS meeting in Vienna.

TRADEMARK REPORT

Dr. Hoehn reported that the trademarks for IPRAS and IPRAF have been duly registered and the bills have been paid. Dr. Nicolai is to be publicly commended for the extra effort that he put forth to make this happen.

IRAQI PLASTIC SURGEONS TRAINING

Dr. Lari and others from Kuwait reported that the planned meeting scheduled for Kuwait City in May had to be postponed. The issues, which remain to be resolved, include the composition of the faculty, the content and format of the teaching session; and the sponsorship. It was agreed that the sponsorship should come from the Kuwaiti Society and the Ministry of Health of Kuwait. Dr. Lari will keep the EXCO abreast of developments.

ENDORSEMENTS

Endorsements have been granted to the Budapest Breast Symposium (Dr. Gulyas); the Lebanese Society for its Annual Burn Symposium; the Argentinean Society's Congress of Plastic Surgery; and the Vth Rhinoplastic Forum in France. A major issue developed in the endorsement of MEPLAST—2005 but timely withdrawal of any endorsements could not be made.

Several issues regarding the policies of IPRAS endorsement were discussed. It will need to be determined at what level IPRAS will endorse a meeting and, conversely, at what level is support extended and at what level is support withheld.

ACTION: Referred to the Policy and Procedures Committee (Daver)

RESPONSES

On behalf of IPRAS, Dr. Hoehn referred Taschen Publishers, publishers of the Illustrated Book on Aesthetic Surgery to Dr. Eisenmann-Klein for response.

Minutes from the IPRAS EXCO Meeting - *Continued*

A request for a charitable contribution by the Oxfam Charitable Trust was denied.

Several requests for links to commercial websites were turned down.

RECOMMENDATIONS

Professor Mohammed Sobhi Zaki was referred to the journal, *Aesthetic Surgery Techniques*, for membership on their Editorial Board.

INTERNATIONAL EXPOSURE

The IPRAS booth was not brought to the Asian-Pacific Meeting because shipping into and out of India posed a problem. However, IPRAS and IPRAF are sharing a table with ISAPS in the exhibit area with meeting materials.

CORRESPONDANCE

Dr. Hoehn reported that he had sent a letter on behalf of the IPRAS EXCO and the entire IPRAS/IPRAF family to the National Secretaries of member countries stricken by the Tsunami.

IBIR

Dr. Topaz reported on the current activities of IBIR. It has expanded its database and is encouraging all members of the EXCO to participate. Problems with compatibility with the NABIR and TOPS are still unsolved, but are being addressed. A further report will be available in August at the EXCO meeting in Vienna.

FINANCIAL REPORT

Dr. Hoehn reported that the current balance is \$33,386.00 USD as of March 15, 2005.

The 2005 billing cycle began in February and a second mailing will be held in April. Countries will be reminded that their members will not be able to participate as presenters, guest speakers, or moderators if the country's dues are not current.

Dr. Hoehn proposed, based on spread-sheets prepared by the Secretariat, that \$15,000.00 of the surplus from 2004 be returned to those EXCO members who attended the Houston EXCO meeting. This returned \$833.00 to each of 18 attending members.

ACTION: Motion was approved 10 to 3.

COMMITTEE REPORTS

Nominating Committee

Dr. Garcia-Velasco submitted a policy statement which the Committee had recommended. This would develop a mechanism for widespread input into the nominating process. Information would be sought from each of the Sections and from the geographic areas to be used in formulating the slate of EXCO members, the General Secretary, and the National Delegates.

ACTION: Motion approved.

Budget and Finance

Dr. Hoehn reported that Dr. Iverson had been called home emergently. However, he had reviewed the financial spreadsheets for 2004 and the proposed budget for 2005 and approved both for presentation.

Dr. Hoehn reported that several inquiries have been received regarding the development and adjudication of the dues structure of IPRAS. The Secretariat has initiated a review of the dues structure and its relationship to the GNP tables on which it is based so that the entire dues structure can be restated for the 2007 to 2011 IPRAS cycle. The EXCO was reminded that no changes could be made in the dues structure without approval of the Council of National Delegates.

Communications

Dr. Habal reported on the GLOBALPLAST. He discussed the issue of archiving the past issues of GLOBALPLAST. He will report further on the costs involved.

The "Face Lift Panel" which was held in Houston has been rewarded with critical success. The journal *Aesthetic Surgery* has requested permission to publish the Panel. This was granted.

Alfred Berger will host the next Panel and the subject will be Tendon Surgery.

A plea for photographs taken at the various meetings and Section Congresses was made. They will be added to the reports of the meetings. Please forward to Dr. Habal or to Jeff Dumont at the Secretariat.

Policy and Procedures

Dr. Daver, and his Committee, presented the IPRAS Policy Manual for approval.

ACTION: Motion passed

Ethics

Dr. Al-Numairy outlined the plans for the Committee, which will include a survey of the teaching and practice of ethics in plastic surgery.

IPRAF

In Dr. Hinderer's absence, Dr. Hoehn reported.

The Minutes of the meeting in Houston were received and approved.

The EQUAM report was presented by Dr. Topaz.

The Consensus Declaration on Breast Implants was distributed. The next meeting is scheduled for 2006. A time and date will be announced.

Dr. Nicolai presented the report of the BioMaterials Committee. A discussion on injectable silicones followed.

Dr. Hoehn reported that no further contacts with the Rotarians and with RSVP have been made.

Requests have been received for old plastic surgery textbooks and journals. No further information was available.

AD-HOC COMMITTEES

IPRAF Review Committee

No report.

REPORTS OF SECTIONS

Asian-Pacific Section

Dr. Chen, Secretary General of the Section, reported on the success enjoyed by the attendees of the meeting in Mumbai. He congratulated Dr. Daver and the Organizing Committee of the Indian Association on a job well done.

European Section (ESPRAS)

Dr. Nicolai, Secretary General of the Section, reported that ESPRAS 2005 will take place in Vienna, Austria from August 30, 2005 to September 3, 2005 under the organization of the Austrian Society and Dr. Manfred Frey. He invited all to attend.

Dr. Nicolai reported that he had been approached by the British Journal of Plastic Surgery to establish a formal relationship. He requested an opinion from the IPRAS EXCO as to the appropriateness of such an affiliation. A lengthy discussion of the pros and cons followed.

ACTION: A formal affiliation with the BJPS should NOT be established.

Iberolatinamerican Section (FILACP)

Dr. Berrocal, the Secretary General of the Section, reported on the activities of the Section. The next meeting is scheduled for March 29 to April 2, 2006 in Buenos Aires, Argentina. All are welcome.

PanAfrican Section

No report.

PanArab Section

Dr. Al-Numairy, the Secretary General of the Section, reported that a combined meeting of the PanArab and the PanAfrican Section will be held in Marrakech, Morocco from April 14 to April 17, 2005. All are welcome.

REPORTS FROM GEOGRAPHIC AREAS

Western Asia

Dr. Lari reported that a group of plastic surgeons will meet in Tehran, Iran in May, 2005 and the Iraqi Plastic Surgeons have been invited. This will be sponsored by the Iranian Society.

No other areas presented formal reports.

REPORTS OF THE CO-OPTED SOCIETIES

ISAPS

Dr. Goes, the President, reported on the activities of the Society. The Houston Congress was a great success with excellent attendance.

Their next biennial meeting will be held in Rio de Janeiro, Brazil from August 2 to 6, 2006.

Dr. Eisenmann-Klein raised the issue of office surgery accreditation. She indicated that the leadership of ISAPS was in communication with the Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) to develop an international program.

WRMS

Dr. Morrison reported that the Society had developed guides for the scheduling and the conduct of their meetings.

They have established a link with the IPRAS website.

Their next meeting will be held from October 22 to 26, 2005 in Buenos Aires Argentina. Subsequent meetings will be in Greece (2007) and Japan (2009).

IFSSH

Dr. Berger reported that their next meeting would be in Sydney, Australia from March 11 to 15, 2007.

REPORT OF THE BERLIN ORGANIZING COMMITTEE

Dr. Eisenmann-Klein reported that plans are proceeding for the XIV Congress in Berlin. She reemphasized the dates to be June 25 to 30, 2007.

2011 BIDDING COUNTRIES

Canadian Society of Plastic Surgeons for Vancouver, B.C.

Chilean Society of Plastic Surgeons for Santiago, Chile

Emirates Plastic Surgery Society for Dubai, U.A.E.

The Swiss Society of Plastic and Reconstructive Surgery for Geneva, Switzerland

No reports were required or received.

QUADRENNIAL CONGRESS ISSUES

Various questions have been raised and were discussed.

Congresses must be open to all member societies and their members.

ACTION: Motion approved.

Canada asked when they could begin to advertise their bid.

ACTION: Bidding countries may advertise their bids after the bids have been approved by the EXCO and no sooner than 12 months before the Congress at which their bid will be active.

Canada requested the right to make their bid presentation to the EXCO in person. This was granted during the EXCO meeting in Houston. However, no bids can be accepted by the EXCO prior to the 2006 meeting.

OLD BUSINESS

2006 Meeting

The site for the 2006 "Face-to-Face" meeting was contested by:

1. Rio de Janeiro with ISAPS
2. Cape Town, RSA with an ISAPS Teaching Course
3. Sydney, NSW, Australia with IFSSH
4. Berlin, Germany for a site visit
5. Dubai, UAE
6. Hurghada, Egypt with the Egyptian Society meeting

A secret preferential ballot was used to select Hurghada, Egypt. It will be hosted by Professor Zaki in conjunction with the Egyptian Society meeting scheduled for February 15-17, 2006. This timing will allow the By-Laws requirement of accepting bids at least 12 months prior to the next Congress to be satisfied. Members of the EXCO were reminded that the Mumbai meeting required almost 6 hours to conduct all of the business before it. Dr. Hoehn will schedule a full day for this EXCO meeting.

Medallions

Two designs were submitted for consideration by the EXCO. A lengthy discussion ensued with the issues being the honorees, how long they would have such a medal, and how to memorialize the medal.

An Ad-Hoc Committee composed of Drs. Olbourne, Zaki and Taylor was formed with Dr. Olbourne as Chair. They will receive input from all EXCO members and report to the EXCO in Egypt in February.

NEW BUSINESS

Dr. Hoehn requested that the Policy and Procedures Committee study the admission requirements for IPRAS. The context of new countries emerging from political strife and divisions has placed new burdens on the membership process.

Dr. Hoehn would like to try to shorten the EXCO meetings by using a consent calendar. A further explanation will be discussed in Vienna.

Dr. Hoehn would like the EXCO to consider a name change in the Confederation to further clarify the mission of IPRAS. The addition of the word "Societies" is proposed. Thus the new name would be "The International Confederation of Plastic, Reconstructive and Aesthetic Surgical Societies". Consideration of this proposal will be had in Vienna and in Egypt.

ADJOURNMENT

After a 4-hour morning session and a 2-hour afternoon "reconvened" session, the EXCO adjourned at 5:10 PM (1710).



The 18th Congress of ISAPS



Submit your abstract online at
www.isaps.org

Deadline for Submission
30 November 2005

Budget, Finance And Audit

Ronald E. Iverson, MD, Chairman
Ali Al-Numairy, MD
D. Julio Kirschbaum, MD
Abdul-Reda Lari, MD
Jean Philippe Nicolai, MD, PhD

Charges:

Budget Approval
Audit of Income and Expenses
Business Advice and Consent on Activities of the General Secretary and the EXCO

By-Laws

Onor Erol, MD, Chairman
Yu-Ray Chen, MD
Krzysztof T. Drzewiecki, MD
Kenneth Salyer, MD
Mohamed Sobhi Zaki, MD

Charges:

Review By-Laws
Suggest Changes to Improve IPRAS Function

Communications

Mutaz Habal, MD, Chairman
Manuella Barrocal, MD
Thomas M. Biggs, MD
Riccardo Mazzola, MD
Norbert Pallua, MD

Charges:

Website Oversight
Webmaster Selection
GlobalPlast

Policy And Procedures

Baman Daver, MD, Chairman
Yoon-Ho Lee, MD
Wayne Morrison, MD
Aldo Mottoro, MD
Russell J. Walton, MD

Charges:

Meeting Site Selections
Teleconferencing Issues
Times
Frequency
Procedure Manual

Nominating

Manuel Garcia-Velasco, MD, Chairman
Alfred Berger, MD
Kiyonori Harii, MD
Alastair Lamont, MD
Norman Olbourne, MD

Charges:

2007 Slate Of Exco Members And
General Secretary

Scientific Congress Committee

Johann C. Bruck, MD, Chairman
Alfred Berger, MD
Rolf Olbriesch, MD

Charges:

2007 Congress

News from a Plastic Surgery Society - Egypt

The 35th Annual Meeting of the Society was held on 15-18 February, 2005 at the Isis Hotel-Aswan under the title *Anti-Aging Issues in the Non-Aged Land of Pharos* in collaboration with the European Association of Aesthetic Surgery.

The new council of the society was elected as follows:

Honorary President:	Farid Mustafa
Honorary Vice-President:	Hassan Badran Mohamed Sobhi Zaki
President:	Ali Mouftah
President-Elect:	Ekram Seif
General Secretary:	Ahmed Adel Nour Eldin
Members:	Ahmed El-Sharkawi Fawzi Hamza Fouad Ghareeb Helmi Shalbi Mohamed El-Hadidy Mohamed Kadry Sobhi Heweidi Taher Ismail Hussein Saber

Submitted by Dr. Mohamed Sobhi Zaki

DON'T MISS ...



THE 10TH CONGRESS OF ESPRAS -
THE EUROPEAN SECTION OF IPRAS
30 August - 3 September 2005
in Vienna, Austria

Visit www.medacad.org/espras/



IPRAS 50-Year Statement



As the International Confederation of Plastic, Reconstructive, and Aesthetic Surgeons (IPRAS) celebrates its 50th Anniversary, it is time to reflect on its history, its activities, and its accomplishments. This will allow IPRAS to re-examine its goals and objectives and restate them in light of IPRAS's role in the world of plastic surgery.

IPRAS began as the solution to the need of the specialty to present the emerging contributions of plastic and reconstructive surgery to the entire world of medicine. IPRAS was formed in 1955 by an international group of plastic surgeons in Sweden in order to bring order and harmonization to an evolving specialty. It originally began as the IPS (International Society of Plastic Surgeons), becoming known as "Confederation" in 1959 at the London congress. "Reconstructive" was added to the title in 1967 at the Rome congress. Men, who became giants in plastic surgery, such as Skoog, Broadbent, Sanvenero-Rosselli, and Manchester, saw the need for an international organization which would provide a forum for the discussion and implementation of scientific advances in plastic surgery. The countries with the largest concentrations of plastic surgeons pledged their support for the concepts envisioned. The first International Congress was held in Uppsala, Sweden and was acknowledged by all plastic surgeons involved to have accomplished the goals anticipated.

In 1992, the emergence of aesthetic surgery as a major sector of plastic surgery prompted IPRAS to add the word "Aesthetic" to its original name, the International Confederation of Plastic and Reconstructive Surgeons (IPRAS).

Organization and Governance

IPRAS has grown steadily over the past half century and now is proud of the 91 member countries, representing almost 14,000 plastic surgeons. There are 2 countries which will be added as Provisional Member Countries this year and will be confirmed as Full Members at the next official meeting of the Council of National Delegates. Five additional countries have expressed their interest in joining IPRAS.

The need for regional interaction in plastic surgery led to the formation of Sections within the structure of IPRAS. At present, five Sections represent both geographic and cultural groups throughout the world. They include the European Section (ESPRAS), the Iberolatinoamerican Section (FILACP), the Asian-Pacific Section, the PanAfrican Section, and the PanArab Section. These groups host Quadrennial Scientific Congresses on an alternating 4-year cycle.

The governance of IPRAS is patterned on the structure of the United Nations and is designed to provide all countries with the opportunity to participate in its activities. The decision-making body is the Council of National Delegates

which is composed of one representative from each of the Full Member nations. The major plastic surgery society or association, which represents all of the qualified plastic surgeons in the country, selects this representative. The Council takes all official actions for IPRAS, selects the next host country for the Quadrennial Congress, and elects the members of the Executive Committee (EXCO) and the General Secretary.

The EXCO manages the affairs of the IPRAS during the 4-year interval between the meetings of the Council of National Delegates. Members of the Council are also charged with the communication of issues affecting plastic surgery between the EXCO and the member national society or association. The Council establishes the dues structure and adopts the budget on the recommendation of the EXCO. All minutes and actions of the EXCO are presented to the Council of National Delegates for ratification at their quadrennial meetings. The General Secretary coordinates the day-to-day management of IPRAS with the assistance of the Executive Secretary and the Secretariat.

The current EXCO has 34 members. Fifteen members represent specific geographic areas of the world. These members are proposed by the Nominating Committee of the EXCO and elected by the Council of National Delegates to a 4-year term. Each of the 5 IPRAS Sections is represented by their respective General Secretary or Coordinator. Special areas of plastic surgical activities are represented by 4 Co-Opted Societies. They are the International Society of Aesthetic Plastic Surgery (ISAPS), the International Society of Craniofacial Surgery (ISCFS), the World Society of Reconstructive Microsurgery (WRMS), and the International Federation of Societies for Surgery of the Hand (IFSSH). The Editor of the on-line newsletter of IPRAS, GLOBALPLAST, and the Chairs and President of the next Quadrennial Congress are appointed to the EXCO. A Deputy Secretary General, a Parliamentarian and a Historian complete the EXCO. The Executive Secretary attends the EXCO in an ex-officio capacity.

In 1992, IPRAS established a not-for-profit foundation, the International Confederation of Plastic, Reconstructive, and Aesthetic Surgery Foundation (IPRAF), to coordinate the educational and humanitarian objectives of plastic surgery. IPRAF is governed by a Board of Directors and coordinated by the Chairman of the Board.

This concentration of plastic surgeons provides the expertise and leadership to allow the EXCO to represent all of the plastic surgeons in the world.

Goals and Objectives

The purpose of IPRAS, as stated in the By-Laws, is to promote the art and science of plastic surgery, to further plastic surgery education and research, and to encourage friendship among plastic surgeons and physicians of all countries.

IPRAS has several major goals that bear restating at its 50-year mark, each of which ultimately should result in improvement in the care and treatment of each and every patient entrusting their care to a plastic surgeon. Each goal should be examined in greater detail.

• Education

The major educational effort of IPRAS/IPRAF is the Quadrennial Scientific Congress. This Congress provides a venue for plastic surgeons from around the world to bring the fruits of their investigative efforts to the critical arena of their peers. Quadrennial Scientific Congresses have been held in the major centers of plastic surgery around the world with the next Congress scheduled for Berlin, Germany in June 2007. Prospective host countries, under the aegis of an Organizing Committee, bid for the right to host the Congress at the current Congress and the Council of National Delegates selects the winner.

Usually, 800 to 1,000 abstracts are received. The vast majority are accepted to be read in either Plenary Sessions or in smaller, topic-specific sessions. This structure has allowed many of the younger plastic surgeons to present their work and have it critiqued by senior plastic surgeons. Plenary Sessions include Panels that explore current research and technical advances in depth by leaders in the field.

However, another educational effort is a priority for IPRAS/IPRAF. This effort is to bring plastic surgery education to those surgeons working in emerging countries who may not have access to such education otherwise. Small groups of plastic surgical educators visit various countries to provide didactic education and technical training for these surgeons and prospective trainees. Current efforts are being organized for Moldova and Central Africa.

• Organizational Assistance

During the past decade, various members of the EXCO, the IPRAF Board, and the Council of National Delegates have visited emerging plastic surgery communities to assist in the organizational development of a national society. The best example of a success is the establishment of the Russian Society of Plastic, Reconstructive and Aesthetic Surgery (RSPRAS). The founding members of this society were drawn from multiple medical disciplines with varying training backgrounds. In a

brief decade, RSPRAS has grown to approximately 400 members and has held four biennial Scientific Congresses, which are scientifically solid and organizationally stable. Two other countries have requested similar assistance.

Over the 50 years of IPRAS's existence, changes in the political structure have presented challenges to IPRAS. At this juncture, all of the affected countries, both existing and new, have been incorporated into the IPRAS structure. Appropriate organizational advice has been provided where required.

• Quality Assurance

The basic driving concept behind the establishment of IPRAS was to ensure that plastic surgery quality was established around the world. From its inception, IPRAS has been concerned by the incursion of untrained physicians traveling around the world performing operations for which they are not trained. With the advent of global interest in aesthetic surgery, maintenance of standards in plastic surgery is critical. In many countries, membership in IPRAS has been instrumental in convincing governmental bodies that the member plastic surgery society should be the qualifying and certifying organization.

In the European Union, for example, IPRAS has supported and assisted the European Committee for Quality Assurance and Medical Devices in Plastic Surgery (EQUAM) in the quest for rational interpretation of scientific data during the debate over the safety of silicone-gel breast implants. Having the expressed support of an international plastic surgery organization was critically important in the deliberations of the various governmental groups, which made decisions about the availability of the implants. As a corollary, the International Registry of Breast Implants (IBIR) has been supported by IPRAS in organizational and financial needs.

In conclusion, the founding plastic surgeons, who gave birth to IPRAS, were committed to the principle that "those who have should provide for those who do not have". This principle continues to guide all of the activities of the leadership of IPRAS/IPRAF.

Albany, New York
May, 2005



James G. Hoehn, M.D.
General Secretary, IPRAS



The IPRAS Executive Secretariat

45 Lyme Road, Suite 304

Hanover, NH 03755

Tel: 1-603-643-2325 • Fax: 1-603-643-1444 • Email: ipras@sover.net

SKIN DEEP FACE LIFT; A GLOBAL PERSPECTIVE

Panel moderator: Mutaz B. Habal

Panelists: Malcolm Paul, Marita Eisenmann-Klein, Richard Sadove and Ulrich Hinderer

Houston Texas

This panel took place during the ISAPS meeting of 2004 in Houston, as part of the activities of the communication committee of the IPRAS EXCO



From left to right

Dr. Malcom Paul, Dr. Marita Eisenmann-Klein, Dr. Richard Sadove and Dr. Ulrich Hinderer

The start of the panel.

I am Mutaz Habal from Tampa, Florida I am a research professor at the University of South Florida and director of the affiliate Tampa Bay Craniofacial and plastic surgery center, I will be chairing this panel for the international society of plastic reconstructive and aesthetic surgery which I am the chair of the communication commission and the both the Globalplast publication a web base publication, and I serve on the executive committee of that organization. We have assembled this distinguished group to give us their views on the global approaches to face-lift. The panel of experts from the United States, Israel, and Spain and Germany and we are going to talk about Skin-deep Facelifts. There is so much controversy regarding primarily why and when to do and how deep we do the skin excision/incision, vectors, limited approaches, long scars short scar, long scar, and no scar. The controversy is certainly not going to be resolved today but we are going to see globally the different views and what the experts have to tell us the process and the goals of what they do. We will have each member introduce him or herself, we will ask questions and each will tell us how they would approach the problem. Let us start by having the panelists introduce themselves and proceed with the designated questions and listen to each one of the panelist point of view.

I am Ulrich Hinderer. I was born in Spain of German parents. I was professor of Plastic Surgery of the University of Madrid and Director of the German Hospital there. For twenty years I had my own private 4-bed clinic and at present have private consultation rooms for Aesthetic Plastic Surgery. I perform my surgeries at the Hospital Madrid-Monte Principe and in the High Care International Hospital in Marbella in southern Spain.

My name is Marita Eisenmann-Klein and I am from Germany. I practice in Regensburg as the director of the department of Plastic Surgery at charity hospital, St. Joseph. I'm currently Deputy General Secretary of the International Confederation of Plastic Reconstructive and Aesthetic Surgery. In Germany people are very conservative. They want a natural look. There are a few bad examples out there internationally and we have to deal with a lot of prejudices.

I'm Malcolm Paul from Newport Beach, California, Clinical associate professor, at the Aesthetic and Plastic Surgery Center at

University of California, Irvine and I co-direct the aesthetic plastic surgery training program for the University.

I'm Richard Sadove. I was born in Chicago and I trained in Norfolk Virginia. I was associate professor of Plastic Surgery at the University of Kentucky and for the past twelve years I have been in full time private practice in Cosmetic Surgery in Tel Aviv.

Habal: Thank you lady and gentlemen we will give each of you a chance to start with a response giving the appropriate question with your opinion after each question as well as a chance to do the closing discussion and remarks. This way we will be rotating the responses to the questions between all of you so we do not have a dominating opinion. I would like for each to start with the principles and follow with the current status in your practice and geographic region. Please stay pertinent and within the frame of the question.

Habal Q: What are the key issues you consider when you do a facelift? What do you think are the important issues that you have to tell your colleagues first and your patients second about what you are doing today in regards to facelifts. Do you think there is a difference in the way you tell your colleagues and the way you approach and talk to the patients?

Sadove A: The key issues in the care of the face lift patients are first of all, do not skip the basics! The first issue comes from the interaction with the patient in terms of asking their motivations and a careful history. This includes going into of any drugs or homeopathic medications that they may be taking and of course the critical issues in physical examination. I often take the blood pressure myself. In this population with unrecognized hypertension which has profound consequences on the care of the patient both inter operatively and postoperatively. As far physical examination is concerned, look for the submandibular glands, the digastric muscles and the mobility of the soft tissue of the face. These are some of the things in the preoperative history and physical examination that are key issues, before you even come to the operating room. After we come to the operating room you want to have an anesthesia staff that the surgeon is comfortable with, experienced in anesthesia of aesthetic surgery patients. My combination facelift and neck lift patients all have nasal intubation and I don't do any of my facelifts, unless it's a facelift, which I do under local anesthesia with sedation. I prefer the control; I'm able to do my best work this way. Inter operatively, one key issues for me are tumescence. I've found that tumescent of the tissues before the incision has done much to increase the safety of the operation and to make the recovery easier for the patient. Tumescence decreases bleeding and helps separate the tissue planes in advance of the scissors. The patients wake up without pain. Technically the keys issues are in the incision selection. I've made the transition to a short scar incision many years ago. There are no more mastoid incisions and my retro auricular incisions are limited to the lobule. Another thing that's key for me in the neck lift portion, it is that I'm no longer dissecting posterior to the anterior boarder of the sternocleidomastoid muscle. This has aided me tremendously in terms of reducing the risks for bleeding because it is my impression that most of the bleeding problems came from perforators or bleeders that were present over the sternocleidomastoid fascia. I do not need to release the skin over the SCM to get the liftoff the neck, because I move the skin in

a vertical direction. It's also helped in reducing the incidence of nerve injury to the greater auricular nerve and paresthesia to that area. So I've been very happy with those modifications in my incision and dissection.

Paul A: I try to understand from the patient what is it they want to accomplish with a facelift. One of the most helpful things is to use pictures of the same patient from twenty years earlier to see what their facial structure was, the soft tissue structure of the face, the volume. We do digital imaging on every patient -- and I morph those images and move things around to get some idea of what we're trying to accomplish with the surgery. Then we set goals and we do things differently than we did before, we are much more concerned about the proper vectors and the proper volume in facelifting. In terms of what I tell my colleagues, it's similar to what I tell my patients and that is to evaluate and listen to the patient as to what is bothering them and why they are coming for a facelift and why they want to change. Do they want to return to the appearance they had twenty years before or do they want to look different than they did twenty years before? And if so, what are the goals and how are you going to accomplish those things?

Eisenmann-Klein A: There is not much difference in the way I talk to my colleagues and to my patients. Most patients have a high level of knowledge about techniques. Germany is a very conservative country as far as facelift is concerned. Patients are very afraid of a stretched look. They want to look natural. They don't want to look as young as possible. They just want to look refreshed. So I stay with a strictly vertical vector in order to prevent any stretching of the perioral musculature. I do a lot of stretching of the SMAS but I have no tension on the skin what so ever. I stay with the short scar, which ends half way up behind the ear with no further incision into the hairline. I always do it under local and sedation because I want the patient to move, to smile, and I want to see how much tension I have. I just feel better doing it under local, it's a question of experience I think. I am pleased to see here that a lot of people are using sutures only, but I do not rely on a single stitch to bring up the SMAS. So I use two continuous running sutures with Cortex in addition to resorbable material.

Hinderer A: Professor Hollander of Berlin initiated the facelift technique, which is now 100 years old. His first publication dates from 1912, but the surgery of skin excision at the hairline and at skin folds was apparently first performed in 1901 on a Polish aristocrat who had convinced Prof. Holländer to improve her face. In the following decades mainly French and German plastic surgeons improved this surgery, namely Passot, Lexer or Joseph, also by removing skin after a limited dissection whether at the hairline or in front of the ear and neck. The results of this subcutaneous rhytidectomy progressively improved by extending the dissection and by meticulous technique trying to hide the incisions. It was Skoog who first used with a lateral approach a deep plane technique to displace and stabilize the buccal fascia and also the platysma for improvement of the lower face and neck, independent from the skin plane displacement and suturing. Paul Tessier who based the technique on his large craniofacial experience then followed this. Tessier started a deep plane subperiosteal lifting from a coronal incision downward and also from a vestibular incision, calling the technique "Mask-Lift". What he wanted was to bring the whole soft tissue mask upward together with, and based on the periosteum, a technique which had many followers. In 1983 I thought that the soft tissues could be lifted directly, instead of lifting them through the periosteum. This was the beginning of my own tech-

nique. The purpose was actually to vertically elevate the anterior mobile part of the face, which is also the area of communication in personal conversations, with stabilization of the temporal fascia. This was done first through a coronal and palpebral approach and soon afterwards through a short 3.5 cm incision above the ear with two small prolongations. The dissection was done down to the naso-labial fold. The main problem was to prevent damage to the branches of the temporal division of the facial nerve, for which I performed many anatomical dissections, mainly to know the pathway of the frontal branch, which according to Baker and Conley is a terminal branch in 85%. I found that the frontal ramus, after leaving the protection of the parotid gland crosses the midpoint between the helix implantation and the lateral canthus and usually divides anteriorly before reaching the frontalis muscle. Therefore in front of this marking I can dissect and displace the anterior mobile part of the soft tissues of the face upward by a pre-periosteal dissection, but posteriorly to the marking the dissection towards the lower face should be performed subcutaneously. Depending on the patient, I think that the periocular and midface lifting should be performed much earlier than it has been up to now. Then we can have a second facelift done about 10 years later at the age of 45, but the long-term result will depend on the stabilization of both the SMAS tissues to the temporal fascia and in the upper eyelid through an orbicularis suspension technique of the raphe and lower orbicularis to the periosteum above the level of the lateral canthus. If the stabilization is well performed the long-term result after 10 years is still better than before surgery. If the patient is older around the age of 45 usually I add a lower face and neck-lift.

Habal: Thank you all. Thank you very much. You can see that globally we almost have the same principles, similar approaches and comparable outcomes. I will stress the facts of which Richard talked about that is primarily about being a doctor first and a aesthetic surgeon second, and Malcolm talking about the vectors the volume changes that are the goals, Marita talking about being conservative so there isn't a drastic change and Ulrich with so many years of experience he has witnessed the changes we have today and the revolution in face lift surgery. We also know that fixation points of the moving soft tissue are essential Marita uses continuous sutures and feel that is a direction for the future so is Malcolm.

Habal Q: Our second question is how deep should we go? We heard about subperiosteal, supraperiosteal, composite, skin alone, skin with fixation, and what do you feel in your region is the accepted and what do you feel surgeons in the world today are going through in their planning? What would you like to tell them? Please start with Malcolm.

Paul A: There is a wide variation around the country and around the world as to the approach to face-lifting and I would say that probably most of the people in the United States are still performing a subcutaneous undermining and a SMAS plication or a lateral SMASectomy. There are many throughout the United States and I am one of them who spend a lot of time doing subperiosteal work. I combine the subperiosteal work with an extended SMAS dissection to be able to rejuvenate all parts of the face. The browlift is performed endoscopically at the subperiosteal level, the mid face lift with a vertical vector of correction is performed subperiosteally, the jaw line and neck are done in multiple different ways, particularly with long bands, the midline of the neck is approached with a midline plication and a back cut to help define the jaw line but also to prevent residual bands from forming and then an extended SMAS dissection from the front of the ear across the zygoma to

below the angle of the mandible to really set the jaw line by doing a 2/3 – 1/3 SMAS flap, 2/3 of the dissected flap is sutured to the posterior fixed edge of the SMAS in front the ear, and 1/3 of the dissected flap is rotated and sutured to the mastoid fascia behind the ear to define the jaw line. When you combine that SMAS dissection with a subperiosteal midface vertical elevation then you have the correction on the central part of the face, correction of the jaw line and neck posteriorly and superiorly, and the amount of the dissection you have to do sub SMAS in the face is less because you corrected the anterior part with a subperiosteal dissection. So even though it's extensive and it goes past the parotid gland into the mobile portion of the SMAS, when i combine these maneuvers I can produce a harmonious result. Most surgeons in the United States are doing either plication or a limited SMAS dissection. Very few surgeons are performing subperiosteal facelifts and very few are performing high SMAS or extended SMAS dissections.

Eisenmann-Klein A: Subperiosteal approach is not an issue in Germany. The problem with subperiosteal approach is that this is not really a technique for everybody, surgeons and patients. We have a lot of people out there who do not do as many facelifts as most of the experts here in the congress and I think it still should be safe for everyone. Therefore I am pleased with the trend towards less invasive and less aggressive techniques. ISAPS offers optimal training in these current techniques,- all plastic surgeons should take advantage of it. I personally use a modification of these techniques,- a SMAS lift with 2 pursestring sutures.

Habal Q: Can you tell us a little more about the pursestring suture that you are mentioning in your discussion, and do you know if everybody in your region sort of looking into that approach or is this something you are doing personally? What are the anatomical landmarks that you use with the purse string?

Eisenmann-Klein A: Actually I did start with this personal approach 10 years ago. I am pleased to see great results from people like Bill Little, Patrick Tonnard and others in the field with facelifts by single stitch sutures. I feel more comfortable to use this as a continuous running suture with Gortex. I started doing it with resorbable materials first. I had some looseness in a few patients after a while on one side and now with the Gortex it seems more reliable. I do it as two independent continuous running sutures but both with a vertical vector.

Hinderer A: Well, just to finish the first question, usually the first procedure is to improve the upper 2/3 of the face. As a vertical dimension of the lower eyelid is much reduced due to the elevation of the lower orbicularis muscle in midface, mostly I only do an upper blepharoplasty, with the orbicularis suspension, published in 1977 in Japan, and Ti-Cron sutures stabilizing the temporal-parietal fascia to the temporalis fascia after bringing the whole soft tissues upward. This gives a very firm stabilization, which acts over many years. Now when I do the lower face and neck I use a separate incision which starts just on the lower hairline of the sideburns and follows in three curves in front of the ear surrounding the lobule, according to Castanares. In a large percentage I use plication sutures of the SMAS, as studied by Vlademere Mitz and Peyronie. Sutures were first used by the French maxillo-facial surgeon Virenque in 1925, who thought that the anterior mobile area of the face has to be stabilized to the fixed part in front of the ear, the parotid fascia and at the masticatory region. In 1959 Gusti Aufricht published his plication technique, which has been very useful. As Marita said there is an increase in using sutures for fixation such as

in the MACS lift of Tonnard and Verpaele and in this congress we have seen good results from the techniques of our French colleagues, Besins and Cornette de Saint Cyr and also Fogli's technique, with a suture of the platysma border to a fibrous ligament at the lobule, which seems to correspond to the Furnas "auricular ligament" but was published before by French anatomists. This fixation seems to be very useful, so that I will try it in the future. I have used the Tonnard-Verpaele MACS lift and in important ptosis the Jost-Levet flap of SMAS tissue, which can be transposed and sutured to the mastoid region.

Sadove A: The issue of how deep is answered by saying that I do a broad skin undermining with a plication of the SMAS in the classic "SMASectomy" location, with interrupted and running sutures of a braided polyester suture. But each individual surgeon chooses the technique that gives him/her the best results. Of course, good surgeons get good results. I'm not raising the SMAS because I am able to tighten the jowl and jaw line effectively with the low plication. The upper face needs more of a pull on the cheek pad and skin, which I do with advancement into the temporal area. This gives results that I'm happy with and also shortens recovery time. Patients are very demanding of getting back to normal activities of daily living quickly I'm concerned that deeper subperiosteal dissections of the central face delay recovery times. If I can give my patients more rapid recovery with the same results as a technique that gives a longer recovery time, everyone would choose the technique with the faster recovery. I just don't see that the deeper approaches give better results.

Habal Q: Thank you. You can see again the as we had with our first question our variations are modest; the principles are about the same. This next one needs a very short answer for each of you and please just sort of list the procedures that you do that you feel are important ancillary procedures that are now performing and to be added to the facelift procedure, you can mention these ancillary procedures without going into details of how and why?

Eisenmann-Klein A: Let me start with what I do NOT dare to do: I do not dare to combine a facelift with a peel because I think it is dangerous to add further compromising to the lymph drainage. I think it's enough to do the facelift alone. But, what I do almost always, is: I add fat and fibrous tissue from the SMAS to the nasolabial fold through a small incision at the alar base. I form a channel and fill the tissue in. I've been doing this procedure for five years and I am quite pleased with the results. It works better in my hands than fat injection.

Habal Q: Is this a dermal graft or a fat graft?

Eisenmann-Klein A: It's a composite graft, - fat and dermis.

Paul A: What I do takes most of the day to do, because it's almost always everything from the endoscopic forehead and midface surgery all the way down to the lower neck region and it takes several hours to do that. I will do some injections of Restylane or Hyaluronic Acid at the same time at the labial region. I will do a dermabrasion if indicated. I no longer do a laser resurfacing around the mouth, I gave the laser up probably about seven to nine years ago because of the concerns of hypopigmentation and the long healing time and the redness. I do laser for the lower lids if all the patient has is small fine wrinkles and there's not a need to a formal blepharoplasty. I have added the SMAS graft as mentioned by Marita, which I think it is a very nice graft used as a sort of fascial

fatty graft and that works well too. I don't do full face resurfacing at the time of a facelift. I wouldn't do it because of the risk of devascularization the flap. I do not inject Botox into the eyelids at the time of a blepharoplasty because of concern of interference with the blink reflex.

Hinderer A: If a patient needs and if he accepts, on the one hand I add profile plasty procedures i.e. rhinoplasty, chin augmentation or reduction or malar augmentation, the latter published in 1971, indicated when there is a real hypoplasia and not a flattening due to soft tissue ptosis which should be corrected by the midface lift. But on the other hand the lip region is what I think shows the patient's real age, if it is not corrected on some patients around 45 or 50 years, it shows the typical vertical "code bars".

Habal Q: You mean the vertical lines.

Hinderer A: Lines, it has a name.

Sadove A: Smoker's lines we call it

Hinderer A: Yes, It is Smoker's lines? Well also deep wrinkles, the nasal labial folds, "marionette" lines. At this age the lip becomes elongated and flat and loses its concavity. Treatment is easy using a subgaleal fascia graft when doing the lifting of the upper 2/3 of the face. This is located between the temporal-parietalis fascia and temporalis fascia, which in the US are called the superficial and deep temporal fascia, which actually does not correspond to the nomina anatomica, but is known by everybody in the States with this nomenclature. In between is the subgaleal fascia, which can easily be dissected. Through an incision at the naso-labial junction the skin can be separated from the orbicularis oris muscle down to the vermilion and the fascia inserted in between and sutured with two stitches at the level of the nasal labial folds. Then the extra skin is removed including at the base of the nostrils so that the suture is practically invisible after a short time. This tissue is also used for insertion in deep naso-labial folds and narrow lips if necessary, similar to the use of other autologous tissues, as Marita said.

Sadove A: Ancillary procedures with facelift: I would answer both surgical and non-surgical. First of all surgically we've got the brow lift, blepharoplasties, and neck treatment. But I would also add that there are times that just tipping up the nasal labial angle in an elderly patient with a witch's nose can add much to enhance the appearance. Grafting/augmentation of the nasolabial folds is helpful at times with use of the subplatysmal fat as a donor site. Chin implants can be a wonderful addition. The non-surgical ancillary treatments would include peeling. I differ from my colleagues in that I feel that peeling of the central 1/3 to 2/3 of the face in non-undermined skin is a very safe thing to do. However, I also agree that peeling of the lateral third of the face on undermined skin of the face is a very dangerous thing to do. I do a very light laser peel of the skin of the central third of the face. It often adds exponentially to the quality of the result. The lateral skin suffers less from dyschromia and any mild color mismatch can be easily treated with home peeling/ night creams. Other non-surgically ancillary procedures would include injections of filler materials in the lip line and/or the nasal labial folds.

Habal Q: Thank you ladies and gentlemen. The next two questions are very short and we would like to hear what you feel about these issues, as well as your personal ideas. We already know we've been doing facelifts for 100 years, do you think the changes

we are witnessing today are an evolution or they have reached this stage with revolution of the technics and treatment? are those changes sort of trial and error or is it a revolution that we are living now in revolutionary period? We looked at the past and we are suddenly saying what we did in the past was not right and we are not going to do everything same way because that was wrong. We are going to do it the right way this time and this is where the revolution starts. Let's start with you Richard; you're the youngest surgeon here and you represent the young plastic surgical generation.

Sadove A: Well, I think it is a little bit of freeing your mind from certain dogma that we were taught. The best example of that is the short scar facelift. It's healthy that we question what we do. We were taught that one must carry the incision back to the mastoid. But people rightfully asked are these approaches really necessary? How much skin are we removing? is there a need for that and can we also do a similar or better job without doing this long incision? So, yes, it was also a bit of trial and error. One of the hallmarks of our specialty is that we're never satisfied. We're always trying to improve what we do. It's a very healthy thing that we always ask ourselves these questions and continue to seek better solutions.

Paul A: I think what we're witnessing probably in the past ten years I would say, maybe eight years, is a revolution of how we approach the aging face because if we were evolving we would just extend the technique and try to make it safer and easier to teach and so forth. What we've done is changed our thinking causing a paradigm shift in the thought process concerning the way we move the tissue in the face. What we now do really counter the way things are really aging. Prior techniques were creating deformities by moving things in directions they were not meant to move because they didn't begin in that direction. They didn't begin to age from lateral to medial or anterior posterior. They began superior to inferior because of Newtonian physics, because of tissue dropping and being held in place in various parts of the face by the retaining ligaments. The retaining ligaments of the face not only determine vertical descent but also as I mentioned yesterday, the zygomatic cutaneous ligament is a ligament that determines a vector of aging, which is really inferior and medial. The midface drops vertically and medially so correction must not be just straight superior. It has to be more of a vector that brings things up and anterior, not just straight up. So having said that I believe there's a revolution of thinking because now we are separately looking at the components of the face and adjusting the vectors much differently then we did before so we didn't evolve to that. We looked at the results, some that were terrific, some that looked operated on, and tried to decide what we were doing that was not right minded, we were not thinking the right way and that's what I believe would be defined as a revolution.

Habal Q: So it is a revolution for you, it is questioning our colleagues, Richard, and our predecessors and Marita, what do you think?

Eisenmann-Klein A: Looking at the original work of Hollander: a lot of people have been doing his technique ever since and we cannot blame them for doing this without a SMAS-lift, since there were studies out there saying the results were exactly the same with and without SMAS. I am very happy about the change in paradigm: people are more aware of a vertically oriented vector, less scars and safer techniques. It will take another ten to fifteen years until we can judge whether the new techniques give us long-lasting results.

Hinderer A: Well I think that the subcutaneous technique is still indicated for example in patients with thin subcutaneous tissue and many small wrinkles due to an exaggerated exposure to the sun. The subcutaneous lift combined with a plication of SMAS tissue will give an excellent result. However, I think that the vector of tissue displacement changed with the deep plane surgeries more towards a vertical vector as the purpose is that of an elevation of tissues or "lifting" with only a minimal backward pull preventing what one of my patients called "a high speed look". At present there is a tendency to do less invasive techniques, which actually began with the mini-invasive endoscopic technique or of the use of suspension sutures, initiated by Virenque and used in the neck by Jim Smith and more recently by Lassus, by Tonnard and Verpaele, and at present by Besins, Cornette de Saint Cyr and Fogli. Even less invasive are the Aptos threads by Sulamanidze. These may be useful for example as an addition to a minor correction of the lower face, when a periocular and midface and vertical lifting is performed, for an additional improvement in secondary facelifts with insufficient results, or even in patients who do not wish to have a facelift performed yet and only accept a blepharoplasty. In this congress we have seen very good results. The question is however how long is the result lasting. I have almost not seen long-term results; let's see from seven years onward. I have published long-term results several times, between seven and twelve years and, as Bob Goldwyn suggested to me many years ago, showing also my worst results, as this will give us the possibility to better compare the results from different techniques. As a final remark: I received a letter from a prospective patient from the States who at first seemed confident about my technique until she asked how many cases had I operated with the vertical facelift technique. I informed her at that time that I had operated around 650 patients, to which she refused stating that she would never go to a surgeon with such small experience! Actually there is confusion between quality and quantity, although this number is large enough to prove its viability, without needing to operate thousands!

Habal Q: Very nice variations in approach and thinking to the area of the face; thanks. We have really finished the substance of our discussion today and what we have planned. The next ones are using our imagination, thinking, and experience in defining the next step. What are the future directions of what we do with face lifts operations? Is it doing more, doing less, spending more time on fixation and stabilization, and the significance of down time for the patients? What do you think is the next generation of plastic surgeons will do, and what to look for in the future? We'll start with you Marita.

Eisenmann-Klein A: I think we shall end up doing less because there are more patients who think about facelifts, more plastic surgeons who do not do more than twenty or thirty cases a year. The techniques need to be safe. What we've seen so far with the new techniques, which are less invasive, is convincing. The question is whether they last long enough. I believe less invasive techniques are safer for the patients. It is inevitable that patients will end up with someone who has not so much experience. I believe that we have a collective responsibility for these patients.

Sadove A: Well I think we will see a continued trend for less invasive rejuvenation. Although this includes the epidermis, we'll also see an increased effort at external energy sources that will try to tighten the dermis without injury to the epidermis. This means to get some skin tightening without injury to the epidermis and its concomitant downtime. Surgically, the future in surgical treatment

of the face will have to address the un addressed problems that we have today. First, we still have problems of ptotic submandibular glands, which remain un addressed. I think that we'll see surgical solutions to submandibular gland ptosis. Second, we'll see more treatment of the digastrics muscle in the surgical treatment of the neck. Finally, because of the fact that today, the facial skin is moved superiorly instead of posteriorly, sometimes we have a problem of skin bunching up in the temporal area. We're going to see some changes in the management of the temporal scar to deal with this problem also.

Hinderer A: I think that there is an increasing tendency, related to publicity, to use less invasive techniques. However my opinion is that "mini-lifts" with "mini-dissection" and "mini-stabilization" only provide "mini long-term results". I prefer to start at a younger age doing a facelift with good stabilization points, which provides a good long-term result. Whenever possible it should also be a technique with a short scar invisible within the scalp. For the lower face and neck it needs to go around the ear but in most patients it is not necessary to prolong the scar back into the mastoid region when a more vertical plication technique or suture suspensions are being used.

Paul A: I think that's a very exciting question because at least in the United States, the reality TV shows, medical TV shows, Extreme Makeover and so forth, and the newest one 90210, have created a level of awareness at least in the American public of the possibilities you can achieve when you combine aesthetic surgery, cosmetic dentistry, laser vision correction, skin care, diet, exercise, anti-aging, all those. So the patients are asking for more and the question is can we deliver the non-ablative techniques in trying to build up the collagen? To my mind the questions are 1. Are these approaches going to offer long term, results. If you perform non ablative techniques, such as radiofrequency, meso therapy, and other tightening procedures, that really also work at the fat level are you going to make it more difficult for us to come back five years later to perform a facelift when the tissue has been treated with radiofrequency or other modalities. I don't know the answer to that. Can you do a lesser procedure in a younger man or woman and avoid doing bigger procedures later on and the only way we would know that is to take a set of identical twins who agree to let one age and other one do surgery at age forty and see at age sixty who needed what. It would be interesting to see what happened. I think at least in the United States the shift now is to do more at a younger age and then to maintain what you have rather than totally rejuvenate the entire face but put things back where they were in a very harmonious way and not do very aggressive procedures but do a very good procedure the first time, which cannot be done in my mind with little incisions. We have to reposition the soft tissue, the SMAS and so forth. And then the last thing I would say, and I've done the purse string the past two years, I did every facelift with the purse string and then I went back to the SMAS dissection, I go back and forth to see what works the best for my patients. But if those procedures that were described so many years ago really worked well then why did some surgeons decide to go under the SMAS to make the jaw line better? Maybe we can do just as well with purse strings. Maybe because some technics have been out five years now, some of those have done very well for five years If we had all the answers would not be having this panel discussion today.

Habal Q: Excellent. Well I think the interesting thing is besides being on time. We all agree that the desire of every man and women is to keep looking young, and if we can provide an educa-

tional tool for them to know that it can be done then it is up to our plastic surgeons in the fields to carry on the tasks. As we are here at the International Society of Aesthetic Plastic Surgery in Houston Texas and we heard many papers yesterday, the day before and the this morning. If you could just list one or two pearls that you will go back home to your country and to your colleagues and tell them this is what I learned today. We'll start with Ulrich.

Hinderer A: I would say that Fogli's technique of elevating the platysma with just one suture to do the fibrous fixation at the lobule impressed me by its result. On the other hand combining the Besins technique dissection to the naso-labial fold with three stabilization stitches up ward, is also worth trying, but as Malcolm said before, we do not know how long this will last. I do not use laser but the combination of stitches plus resurfacing techniques has provided good early results in the hands of many colleagues.

Eisenmann-Klein A: I cannot wait to go home and use Oner Erol's technique of lip elevation in some of my patients. I did not have good solutions for the thin and aging upper lip in the past, - so I'm really excited about this.

Habal Q: So you think that particular presentation that was given yesterday was really the hallmark of what you have heard in the whole meeting?

Eisenmann-Klein A: Yes - because the other papers were very close to what I've been doing, - more or less. Nothing was totally new for me but this is really innovative. Injecting collagen into the upper lip to elevate it, is not the answer to all problems I have with long lips. This could be the solution. I wonder whether it will work as well with my patients, since some of them have much thinner skin than the patients in Turkey wher the author of that paper practices plastic surgery.

Habal Q: If we publish his paper within the coming three months you will read it?

Eisenmann-Klein A: Definitely.

Paul A: Well I would agree that Fogli's technique, at least the anatomy he described of this ligamental structure that is anchored to the skeleton much like the temporalis fascia is to the zygomatic arch, I was very impressed with the results of that technique. I thought that was terrific and I think I would try it and I don't know why that should be different then taking the SMAS to the mastoid

fascia, I don't know why one would be better than the other and over time some of these things do come loose, some patients look terrific and others develop a relapse for various reasons. I don't know, but we do know that the SMAS techniques will last twenty years. I know that if we dissect the SMAS and divide the flap, it will last a long, long time if we do it correctly. So I'm taking back that and the second thing I'm taking back is a fascinating display in the exhibit area of the use of three dimensional technology to take a video tape and have models made to educate patients and colleagues on how you do procedures and the procedures that Terry Besin showed yesterday on the mid face rejuvenation is shown in that exhibit. I really thought it was interesting. The 3D's is where I think everything was moving in terms of imaging and teaching.

Sadove A: There were other things going on at this wonderful meeting. Two things are going home with me. One is the clear realization that all of us, all over the world have much more in common than we have differences. We share the same medical/legal problems, the same problems of lesser societies, which threaten our welfare. It's clear that we have to give more of our personal time and efforts, through this society, in order to work to our common betterment. The second thing that I'm going home with is a message from our key note speaker Story Musgrave. He showed us how we look from outer space and reminded us that we're all global citizens. We all have to work together and get along.

Habal: That really is a very good ending for our very provocative discussions we had today. I thank you all very much and this is really very interesting and I'm sure our colleagues around the globe will really value and look forward to this being published web. We will use some of your highlighted statements, I have taken some notes, to put some of those highlights beside what you have. Does anyone else have anything else to add? I see none, This terminates our panel discussion on Skin-deep facelifts. Again, thank you very much. We are all one family globally the family of plastic surgery. Any colleagues who read this panel discussion and have any question or clarification on any point discussed, please do forward those queries to us

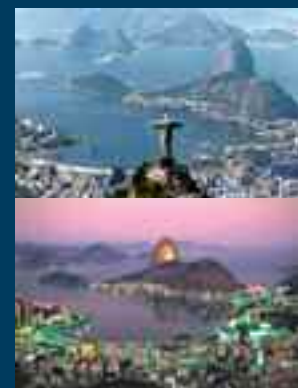
Panel Moderated by:
Mutaz B. Habal, MD, FRCS
Tampa Bay Craniofacial & Plastic Surgery Center
801 West M. L. King Blvd
Tampa, FL 33603 USA
mbhabal@gte.net



The 18th Congress of ISAPS Rio de Janeiro, Brazil August 2-5, 2006

Submit an abstract online
Visit www.isaps.org
Deadline: 30 November 2005

Host Society Sociedade Brasileira de Cirurgia Plastica



Plastic Surgery Meetings from around the World

View an updated list on our website at www.ipras.org

AUGUST 2005

5-7 August 2005

Third Annual Fresh Cadaver FLAP Dissection Course for Reconstructive Surgery

Venue: Duke University, Durham, North Carolina, USA

Tel: 1-919-681-6354

Website: dukepsworkshop.dukehealth.org

17-21 August 2005

Oral and Written Board Preparation Course

Venue: Chicago Illinois

Tel: 1-800-766-4955 or 1-847-228-9900x471

Fax: 1-847-228-7099

Email: registration@plasticsurgery.org

19-21 August 2005

Basic Maxillofacial and Techniques for Plastic and Reconstructive Surgeons

Venue: Chicago Illinois

Tel: 1-800-766-4955 or 1-847-228-9900x471

Fax: 1-847-228-7099

Website: www.maxface.org

24-27 August 2005

20th Annual Breast Surgery & Body Contouring Symposium

Venue: Santa Fe, New Mexico

Tel: 1-800-766-4955 or 1-847-228-9900x471

Fax: 1-847-228-7099

Email: registration@plasticsurgery.org

27 August 2005

Breast Implants: Use, Efficacy and Safety. The Immediate Horizon and Beyond

Venue: Santa Fe, New Mexico

Tel: 1-800-766-4955 or 1-847-228-9900x471

Fax: 1-847-228-7099

Email: registration@plasticsurgery.org

24-27 August 2005

World Burn Congress

Venue: Baltimore, Maryland

Tel: 1-800-888-2876

Website: www.phoenix-society.org

August 30 - September 3, 2005

10th Congress ESPRAS 2005

European Societies of Plastic, Reconstructive and Aesthetic Surgery - European Section of IPRAS

Sponsors: Austrian Society of Plastic Surgery

Venue: Vienna General Hospital, Vienna Medical Academy

Contact: Hedwig Schulz

Tel: 43-0-1-405-13-83-10

Fax: 43-0-1-405-13-83-23

Email: espras2005@medacad.org

Website: www.medacad.org/espras/

SEPTEMBER 2005

4-7 September 2005

International Facial Nerve Symposium

Venue: Maastricht, The Netherlands

Contact: Conference Agency Limburg

Tel: 31-0-43-361-91-92

Fax: 31-0-43-361-90-20

Email: info@conferenceagency.nl

Website: www.conferenceagency.com/facial/

4-6 September 2005

ISAPS Postgraduate Instructional Course

Sponsors: ISAPS and Yugoslav Society of Plastic Surgeons

Venue: Sveti Stefan, Serbia and Montenegro

Contact: Miodrag Colic, MD

Email: congress@passport.zepter.co.yu

Website: www.passport.zepter.co.yu/isaps2005/

4-8 September 2005

10th International Congress on Cleft Palate and Related Craniofacial Anomalies ICC

Venue: Durban, South Africa

Email: cleft20005@nu.ac.za

Website: www.cleft2005.co.za

10-11 September 2005

Canadian Society of Aesthetic Plastic Surgery Annual Meeting

Venue: Quebec City, Canada

Tel: 905-831-7750

11-14 September 2005

Meeting of International Society of Craniofacial Surgery

Venue: Queensland, Australia

21-24 September 2005

11th European Burns Association Congress

Sponsors: European Burns Association

Venue: Estoril, Portugal

Tel: 35-1-21-884-12-01/+351 21 884 14 73

Fax: 35-1-21-884-10-37

Email: info@eba2005-portugal.com

Website: www.eba2005-portugal.com

22-23 September 2005

Annual Meeting of the British Association of Aesthetic Plastic Surgeons

Venue: Royal College of Physicians, London, England

Contact: Laura Manning

Tel: 44-207-430-1840

Fax: 44-207-242-4922

Email: info@baaps.org.uk

Website: www.baaps.abstracts.org.uk

22-24 September 2005

Joint Annual Meeting of ASSH & ASHT

Sponsors: ASSH & ASHT

Venue: San Antonio, Texas

Tel: 1-847-384-8300

Website: www.assh.org

23 September 2005

Functional, Aesthetic & Reconstructive Surgery of the Nose

Sponsors: ASPS/PSEF

Venue: Chicago, Illinois

Tel: 1-847-228-9900x471

Fax: 1-847-228-7099

Email: registration@plasticsurgery.org

Website: www.plasticsurgery.org

24 September 2005

Facial & Periorbital Rejuvenation Symposium

Venue: Chicago, IL

Tel: 1-800-766-4955

24-28 September 2005

Plastic Surgery 2005: The 74th Annual Scientific Meeting of ASPS/PSEF/ASMS

Venue: Chicago, IL, USA

Tel: 1-800-766-4955 or 1-847-228-9900x471

Fax: 1-847-228-7099

Email: registration@plasticsurgery.org

OCTOBER 2005

13-14 October 2005

International Course, Advances in Plastic and Aesthetic Surgery Program

Venue: Marbella, Costa del Sol, Spain

Tel: 34-932-173-366

Email: vcongresointernacional@grupoanima.net

16-20 October 2005

American College of Surgeons 91st Annual Clinical College

Venue: San Francisco, California

Tel: 1-312-202-5433

Email: jaikins@facs.org

Website: www.facs.org/clincon2005/index.html

21-23 October 2005

QMP Aesthetic Surgery Symposium

Venue: St. Louis, Missouri

Tel: 1-314-878-7808

Email: esirianni@qmp.com

Website: www.qualitymedicalpublishing.com/meeting2005

23-26 October 2005

III Congress of the World Society for Reconstructive Microsurgery

Venue: Buenos Aires Sheraton Hotel & Convention Center

Tel: 54-11-4373-6266

Fax: 54-11-5811-1457

Email: info@wsrm-2005.com

Website: www.wsrm-2005.com

NOVEMBER 2005

3-6 November 2005

22nd Annual Meeting of the Northeastern Society of Plastic Surgeons

Venue: Ritz-Carlton Hotel, Washington, DC USA

Contact: NESPS Administrative Office

Tel: 1-603-643-2325

Fax: 1-603-643-1444

Email: nesps@sover.net

Website: www.nesps.org

10-12 November 2005

The 59th Scientific Meeting of the KSPRS

Venue: Wakahill, Seoul, South Korea

Contact: Hee-Chang Ahn, MD

Tel: 82-2-2290-8560

Fax: 82-2-2922-6517

Email: ahnc@hanyang.ac.kr

11-12 November 2005

Instructional Course about Burn Management

Venue: Beirut, Lebanon

Email: aata@terra.net.lb

12-15 November 2005

42nd Congress of the Brazilian Society of Plastic Surgery

Venue: Belo Horizonte, Brazil

Email: sbcpl@cirurgioplastica.org.br

Website: www.cirurgioplastica.org.br

16-19 November 2005

Fillers, Injectables and Lasers for Facial Rejuvenation and Aesthetic Surgery of the Face

Venue: The Waldorf-Astoria Hotel, New York City, NY

Contact: Francine Leinhardt

Tel: 1-212-702-7728

Fax: 1-212-832-9126

Email: fleinhardt@earthlink.net

21-23 November 2005

Rhinoforum

Venue: Marseille, France

Contact: Europa Organization

Fax: 05-3445-2646

Email: europa@europa-organisation.com

JANUARY 2006

13-16 January 2006

The Annual Meeting of AAHS, ASRM & ASPN

Venue: Loews Ventana Canyon Resort, Tucson, Arizona

Fax: 1-312-782-0553

27-29 January 2006

New Horizons in Cosmetic Surgery Symposium

Venue: Indian Wells, California

Tel: 1-800-766-4955

FEBRUARY 2006

2-4 February 2006

The 40th Baker Gordon Symposium on Cosmetic Surgery

Venue: Miami, Florida

Contact: Mary Felpeto

Tel: 1-305-859-8250

2-5 February 2006

X Congreso Guatemalteco de Cirugia Plastica

Venue: Tikal, Peten, Guatemala

Contact: Sociedad Guatemalteca de Cirugia Plastica

Tel: 502-2238-1121

Email: arruga@intelnet.net.gt

23-25 February 2006

Aesthetic Facial Reconstruction in Adults & Children Symposium

Venue: Tucson, Arizona, USA

Tel: 1-800-766-4955

MARCH 2006

1-4 March 2006

Congreso Venezolano de la SVCPREM

Venue: Caracas, Venezuela

Tel: 58-212-9797380 / 9783886

Email: svcprem@cantv.net

12-16 March 2006

Perspectives and Advances in Plastic Surgery Symposium

Venue: Vail, Colorado, USA

Tel: 1-800-766-4955

18-21 March 2006

South African ISAPS Course

Venue: Spier Winelands, Cape Town, South Africa

Tel: 27-11-6401573

Email: isaps@sover.net

29 March - 2 April 2006

XVI Congress of FILACP

Venue: Buenos Aires, Argentina

Contact: Argentina Society of Plastic Surgery

Tel: 54-11-4816-3757

Email: sacper@cirplastica.org.ar

Website: www.cirplastica.org.ar

31 March - 1 April 2006

Body Contouring after Massive Weight Loss

Venue: Dallas, Texas, USA

Tel: 1-800-766-4955

APRIL 2006

11-13 April 2006

9th Congress of the PanArab Association of Plastic Surgeons and the 6th Conference of the GCC Association of Plastic Surgeons

Venue: Manama, Kingdom of Bahrain

Contact: Tariq Saeed

Tel: 973-17-822-873

Fax: 973-17-822-899

Website: www.gulfplast.net

MAY 2006

13-17 May 2006

XIV Curso Internacional de Cirugia Estetica

Venue: Medellin, Colombia

Contact: Comunicaciones Efectivas

Tel: 57-4-250-6091

Fax: 57-4-411-0010

Email: cirujanos@comunicacioneseffectivas.com

Additional meetings online at
www.ipras.org

Add your meeting to this list.

Contact Jeffrey Dumont, IPRAS Executive Webmaster at
dumontj@sover.net

Please provide as much information as possible

THE 14TH CONGRESS OF IPRAS



JUNE 24-29, 2007

BERLIN, GERMANY

WWW.IPRAS2007BERLIN.COM

Dear Colleagues and Friends,

The German Association of Plastic Surgeons is honored to host the IPRAS 2007 in Berlin, a city known for its exciting medical, scientific, cultural and political developments for plastic surgeons from all over the world.

It will be a pleasure to welcome you to the 14th Congress of International Confederation for Plastic, Reconstructive and Aesthetic Surgery from June 24-29, 2007 in Berlin. We invite you to take advantage of the excellent scientific program to be presented at this congress by visiting our website.

Sincerely,

The 2007 Congress Organizing Committee

For more information

IPRAS Congress Secretariat

c/o KIT GMBH

Association & Conference Management Group

Kurfürstendamm 71

D-10709 Berlin

Phone: 49-30-24-603-260

Fax: 49-30-24-603-200

Email: ipras2007berlin@kit-group.org

IPRAS EXCO Meeting

Tentative Agenda
Vienna, Austria
September 1, 2005

1. Welcome

2. Declaration of Quorum

3. Review of Mumbai Minutes

4. Report of the General Secretary

- a. Contract for Secretariat
 - i. Revisions
 1. Calendar year
 - ii. Contract for Executive Webmaster
- b. Activities
 - i. SpamArrest usage
 - ii. Address lists
 1. Changes
 2. Internet contacts with member countries and National Delegates
- a. Information issues within countries
- b. Identification of primary plastic surgery society in a country
 - iii. Representation
 1. GCC Congress – Oman
 2. Section Meetings
 - a. Asian-Pacific Section meeting
 - b. PanAfrican/PanArab Conjoined meeting
 - c. ESPRAS
 - iv. Membership Issues
 1. Bahrain
 2. Saudi Arabia
 3. Macedonia
 - a. Name issue
 - b. Recognition by other bodies and states
 4. Cyprus
 5. Romania
 6. Bosnia-Herzegovina
 7. Estonia
 8. Hong Kong
 - v. Trademark Registration Report
 - vi. Iraqi Plastic Surgeons Training
 1. November 19, 2005
 - vii. Endorsements
 1. Budapest Breast Symposium
 2. Lebanese Society
 3. Argentinean Society's Congress of Plastic Surgery
 4. Vth Rhinoplastic Forum
 - a. France
 5. ISAPS experience with MEPLAST
 6. Policy Issue
 - a. At what level do we endorse
 - b. At what level do we support
 - c. Which meetings get listed on the Website
 - d. Report from Policy and Procedures Committee

7. Responses

- a. Taschen Publishers
 - i. Illustrated Book on Aesthetic Surgery
 - b. Oxfam Charitable Request
 - c. Linkages to commercial websites
- ## 8. Recommendations
- a. Prof. Zaki to Aesthetic Surgery Techniques journal
- ## 9. International Listings
- ## 10. Correspondence
- a. Letter to National Delegates of Tsunami-stricken member countries
- ## 11. IBIR
- ## 12. Financial Report
- a. Current balance
 - b. Dues
 - i. 2005 Billing cycle
 - c. 2004 EXCO Reimbursement
 - i. Passed in Mumbai
- ## 13. 50th Anniversary Activities
- a. 50-year Statement
 - b. Reception in Vienna
 - c. Reception in Chicago

5. Report of the Executive Director

6. Committee Reports

- a. Nominating Committee
 - i. Qualifications for Candidates
 1. Approved in Mumbai
 - a. Wide spread input
 - b. Nominations of Sections
- b. Budget and Finance Committee
 - i. Oversight report for 2004
 - ii. Dues structure Review
 1. Latest GNP data
 2. Review of billing procedures for 2007
 3. When to implement?
- c. Communications Committee
 - i. GLOBALPLAST
 1. Archiving old issues
 - a. Internet
 - b. Hardcopy
 2. Panel
 - a. Face-lift
 - b. Hand Panel
 - i. Berger – Flexor tendon
 - c. Aesthetic Surgery request to publish
 - ii. Website
 1. Report of the Executive Webmaster
 2. Transfer of domain name and registration
 3. Restructuring of "links"

- d. Policy and Procedure Committee
 - i. Policy and Procedures document proposed by Dr. Daver was approved.
- e. Ethics Committee
 - i. Survey report
- f. IPRAF Report
 - i. Minutes of Houston meeting approved
 - ii. EQUAM report
 - iii. Biomaterials Committee Report
 - 1. Liquid silicone injections
 - iv. RSVP/Rotarians Burn Hospitals
 - v. Moldava Teaching Trip
 - vi. Requests for plastic surgery textbooks & instruments
- g. Ad-Hoc Committees
 - i. IPRAF Review Committee

7. Reports of Sections

- a. Asian-Pacific Section
 - i. Next meeting - Japan, 2009
- b. ESPRAS
 - i. Affiliation with British Journal of Plastic Surgery
 - 1. Denied
- c. Iberolatinamerican Section
 - i. Next meeting – Buenos Aires, 2006
- d. PanAfrican Section
 - i. Marrakesh meeting
 - ii. Next meeting – Durban, 2006
- e. PanArab Section
 - i. Marrakesh meeting

8. Reports of Geographic Areas

- a. Europe
- b. Western Asia
 - i. Met with Iranian Society
- c. Eastern Mediterranean
- d. Far East
- e. Africa
 - i. Will host 2006 IPRAS EXCO
 - 1. Hurghada, Egypt, February 14, 2006
- f. Asian-Pacific
- g. North America

9. Reports of Co-Opted Societies

- a. ISAPS
- b. ISCFS
- c. WRMS
 - i. Next meeting – October 22-26, 2005 in Buenos Aires, Argentina
 - ii. Subsequent meetings
 - 1. 2007 – Greece
 - 2. 2009 – Japan
 - iii. Website is linked to IPRAS
- d. IFSSH
 - i. Next meeting – March 11-15, 2007 in Sydney, Australia

10. Report of the Berlin Organizing Committee

- a. June 25-30, 2007

11. Reports of the 2011 Bidding Countries

- a. Canadian Society of Plastic Surgeons
 - i. Vancouver, BC
- b. Chilean Society of Plastic Surgeons
 - i. Santiago

- c. Emirates Plastic Surgery Society
 - i. Dubai, UAE
- d. Swiss Society of Plastic Surgeons
 - i. Geneva
- e. Indian Association of Plastic Surgeons
 - i. Calcutta

12. Quadrennial Congress Issues

- a. Congresses must be open to all member societies and their members
 - i. Approved
- b. When can bidding societies advertise their bids
 - i. Advertising can begin 12 months before the balloting
 - ii. Not until the bid has been accepted by the EXCO
- c. Ability of bidding societies to make the final presentation to the EXCO
 - i. Approved
- d. Can bids be finalized prior to the 2006 presentation
 - i. Denied

13. Old Business

- a. Revisit the site selection for the 2006 “Face-to-Face” meeting
- b. Medallions
 - i. Presentation of samples
 - ii. Discussion of use
 - 1. Several suggestions
 - iii. Committee formed to recommend implementation
 - 1. Norman Olbourne, Chair
 - 2. Prof. Zaki
 - 3. G. Ian Taylor
 - iv. Lapel pins
 - v. Production and presentation dates

14. New Business

- a. Proliferation of uninvited surgeons in developing countries
- b. Requirement for membership in IPRAS
 - i. Referred to By-Laws, Policy & Procedures Committees
- c. Use of Consent Calendar
- d. Consideration of recommendation for a name change
- e. International Confederation of Plastic, Reconstructive and Aesthetic Surgical Societies

15. Special Vienna meeting issues

- a. Request for reconsideration of 2006 “Face-to-Face” Meeting site
 - i. Egyptian Society to host EXCO in Hurghada, Egypt on Tuesday, February 14, 2006
- b. Meeting format for Berlin
 - i. Days for the various IPRAS activities
 - 1. General Assembly
 - 2. Council of National Delegates
 - 3. Opening and Closing Ceremonies
 - 4. EXCO meetings
 - 5. Peripheral meetings
 - 6. Editors Luncheon
 - c. Qatar request for membership
 - d. Nominating Committee slate

16. Adjournment