The Presidential Message

Steven R. Buchman MD
University of Michigan

I want to thank the entire membership for the trust and confidence you have placed in me by electing me as your president. I am honored and humbled by the storied history of this organization and by the esteemed list of renowned individuals in whose footsteps I now follow.

I also want to thank Dr. Mimis Cohen for his indefatigable efforts as your immediate past president on all of our behalf and for his labors toward the advancement of the goals of the Society.

I hope you had the opportunity to join us in Toronto this past October, as Dr. Robert Havlik did an excellent job of organizing a popular and informative pre-symposium as well as an educational general scientific program. ASMS continues to build upon the successes of the past in order to become a more integral and relevant part of our overall specialty. Our organization planned and sponsored 5 panels and two scientific paper sessions and hosted Dr. Ian Jackson as our Converse Lecturer. Dr. Henry Vasconez will take on (continued on page #)

ASMS President’s Address in Toronto

Mimis Cohen, MD
University of Illinois

Uncertain times can be overcome by the mission – and hope – of ASMS

Hippocrates, the father of rational medicine, the man who freed medicine from theocracy, priesthood and magic, wrote almost 25 centuries ago in his first aphorism:

Life is short, the art long, opportunity fleeting, experiment treacherous, judgment difficult.

I first became aware of this sentence when I was about age 10. I had already decided that I would become a surgeon when I grew up, and my late father – a surgeon himself – used this aphorism to caution me about my decision.

He wanted to make sure that I understood early on that, in (continued on page #)
The ASMS continues to maintain its position as the primary organization for education and representation of maxillofacial surgery to plastic surgeons in the United States. Under the leadership of our new president, Steve Buchman, we believe that the upcoming year will represent a milestone for the ASMS, with several key initiatives as outlined in the President’s Message on page one of this issue.

The ASMS Newsletter remains the key component in helping to maintain the visibility of our mission and we strive to make this a forum through which members at all levels can get a flavor of the activities and offerings of our organization. With this edition of the Newsletter we have made a complete transition to a Green publication, having completely eliminated the print version. Not only is this an ecologically friendly transition, but it also allows the ASMS to redirect the cost savings towards our essential missions: education and representation of maxillofacial surgery. An additional change in the Newsletter is the management team who will help to arrange the Newsletter. Lorraine O’Grady of PRRI will be the principal liaison to help with assembly of the Newsletter. PRRI has a long history of management of other key organizations in plastic surgery, and we look forward to their support in producing the ASMS Newsletter.

To produce a Newsletter representative of the pulse of the ASMS, we have assembled a Maxillofacial News Committee who will work throughout the year to develop articles of relevance to our members.

The Newsletter will follow the following format:

- **Historians Corner**: We will publish an article from a past ASMS leader to highlight the origins of the ASMS missions and how these practices have evolved over the years.
- **Resident’s Corner**: We will discuss issues of pertinence to residents related to maxillofacial surgery and how the ASMS can assist them in meeting their needs.
- **CPT Corner**: We will highlight one CPT code of importance to maxillofacial surgeons and discuss how this code can best be utilized as well as potential deficiencies in present utilization of the code.
- **Update of Upcoming Deadlines**: This will include deadlines for ASMS Research Grants, ASMS International Scholar applications, ASMS CRANIO applications, and all upcoming ASMS courses that have been scheduled. We will further elaborate on any of these events as deadlines approach to clarify their purpose and to promote applications.
- **Advertiser’s Section**: We will feature companies that are not currently large contributors to the ASMS. This will help us to expand our corporate network with the potential of providing further resources to our members based on the areas of strength of these corporations. We will also include a section to formally thank these corporate supporters in each issue of the Newsletter.
- **Conversations with the Experts**: Teleconferences will be arranged between 2 or more experts, with each answering questions related to their area of expertise in the management of specific topic in maxillofacial surgery. This will be initiated in the Spring Newsletter with the first of a two-part series on Head and Neck reconstruction to be moderated by Charles Butler.
- **Book Reviews**: We will review one or two books pertinent to maxillofacial surgery. Should any of the members wish that a specific book be edited, please forward this information to Lorraine O’Grady (logrady@prri.com).
- **Case of the Month**: We will publish a controversial case and discuss the diagnosis and potential management of this case.
- **Additional Timely Articles**: Invited articles will be submitted by members of the ASMS based on recent developments pertaining to maxillofacial surgery. We wish for the Newsletter to remain current to changing trends and events in maxillofacial surgery. Should any of the members wish that a specific topic be addressed based on recent progress in this area, please forward these suggestions to Lorraine O’Grady (logrady@prri.com).

We see the ASMS Newsletter as a dynamic and fluid means by which we can distribute information to our members. We wish for each of you to view this as YOUR Newsletter, and you are all welcome to contribute with suggestions for Book Reviews, Additional Timely Articles, or by submitting a Case of the Month.
The ASMS Education Committee has gone through some dramatic changes since I first became a member in 1997. Earlier meetings consisted of the Committee Chair, me, and possibly one additional member. We worked with a short agenda, an unclear mission, and little or no funding. Thanks to the enthusiasm and vision of our leadership, we have grown to a Committee of 28 surgeons with more ideas than we have time to discuss at a single meeting.

For many of us, the chief reason for membership in the ASMS is our educational mission. Our Basic Maxillofacial course, now in its 34th year, continues to change and improve. It has stimulated many young surgeons, who had not considered the specialty of craniofacial surgery, to change their course in life.

Our newest offerings include “Challenges in Cleft Care in Underdeveloped Countries” being offered in Miami on January 16, 2011 and our Advanced Maxillofacial Course, which will be offered in Jacksonville, Florida, February 19-29, 2011.

The Cleft Course in January will address many of the challenges facing a surgeon interested in developing a Cleft team in an impoverished country. Registration for this course will be complimentary for any attendee at the Basic Maxillofacial Course on January 14-15.

The Advanced Course in February provides the next level of training beyond the Basic Course, offering surgeons an opportunity to work with fresh cadavers and to deal with soft tissue, allowing a more realistic experience to practice surgical approaches, various osteotomies, and gain familiarity with osseointegrated implants.

One of the Education Committee’s challenges will be to continue to offer new educational courses that benefit our members and to publicize these courses to residents, fellows, and all practicing surgeons who want to perfect their skills.

One of the Society’s goals over the next year is a complete revamping of our website www.maxface.org. During the Annual meeting in Toronto, one of the greatest pleas from the Education Committee was to build a library of procedural videos on the website. I encourage anyone with a procedural video that they would like to share with their colleagues, to forward to me for consideration by our Web Committee.

There are many ways that the members of the Education Committee get involved including submitting materials to the ASMS Newsletter, the Hyperguide, involvement with the PSEN, and new projects for course development.

I encourage all ASMS members to contact me regarding any new projects you would like to see the Education Committee address.
Residents and Fellows Corner:
Plastic Surgery Residency Training in Craniomaxillofacial Surgery

John Mesa, M.D.

Craniomaxillofacial surgery is a fundamental component of residency training in plastic surgery. Since the consolidation of plastic surgery as a surgical specialty, craniomaxillofacial surgery has been an integral part of its reconstructive armamentarium. The ACGME requires plastic surgery residents to be trained in the care of head and neck congenital deformities like cleft lip and palate, as well as craniomaxillofacial trauma. However, differences in plastic surgery residency training programs such as location, hospital affiliation, population covered, etc., influence the degree of training in craniomaxillofacial surgery.

It has been shown nationally and internationally that specialized patient care is associated with better outcomes at higher volume centers. Multiple surgical specialties like bariatric and cardiac surgery tend to be centralized in high volume centers. Craniomaxillofacial surgery, which takes care of the patient in an multidisciplinary approach involving multiple speech pathology, audiology, orthodontics, ENT, also tends to be located at higher volume centers. Plastic surgery training programs affiliated with lower volume centers may be at a disadvantage in training their residents in craniomaxillofacial surgery.

Plastic surgery residents graduated from accredited training programs should have the training necessary to repair essential craniomaxillofacial problems like cleft lip, cleft palate and/or complex maxillofacial trauma. Low exposure to craniomaxillofacial surgery training during residency could result in decreased skills. These programs would benefit by offering training in a “non-traditional form.”

Elective “travel” rotations at high volume craniofacial surgery centers would allow plastic surgery residents to obtain additional training in craniomaxillofacial surgery. Exposure to the multidisciplinary care team would be of great benefit to the trainee. International mission trips are also outstanding educational experiences for plastic surgery residents, especially in cleft lip and cleft palate. Residents are exposed to a high volume of patients during a short period of time, mimicking the experience at a high volume centers. These experiences may lack the value of long term follow up however the high volume with experienced surgeons counterbalances this. In addition, interacting with multiple surgeons with different techniques from other parts of the world, a resident could learn the technical aspects of many cleft and palate repair surgical techniques.

Another “non-traditional” training model includes virtual surgical training at surgical skill facilities. Virtual training is well established in anesthesia and general surgery training, but still in its infancy in plastic surgery training. Craniomaxillofacial surgery should remain an integral part of the training of the plastic surgery residents. Residency training programs with lower exposure to craniomaxillofacial surgery can complement their craniomaxillofacial resident training with “travel” rotations, international mission trips, and virtual surgical skill labs. Plastic surgeons graduated from an accredited training program should be able to provide excellent surgical care to craniomaxillofacial patients. Plastic surgeons should continue to enjoy the feeling associated with the creation of a repaired smile in cleft lip infant patients or the restoration of a traumatized face.

THANK YOU to the following for their continued support of ASMS

Douglas Ousterhout, MD
David Genocov, DDS
Carefusion

Operation Smile
American Academy of Pediatrics
Lifecell
I have been a member of the ASMS since my plastic surgery residency (almost 20 years). I frequently wonder, what is my place in this organization, and does the ASMS truly represent the interests of the private solo plastic surgeon.

Prior to my plastic surgery training, I was in private practice as a general dentist. After completion of my plastic surgery residency and craniofacial fellowship, I found membership in the ASMS as a natural and comfortable progression into my plastic surgery practice. Historically a majority of the founding fathers of our society were double degree plastic surgeons, however, today a majority of the members in the ASMS have only a MD degree.

As my practice developed over the years I often felt that the ASMS did not represent me as a private practitioner and actually represented the interests of the “academic surgeons”. As my practice grew and developed, I eventually performed more aesthetic surgery, however, the core of my practice was still rooted in maxillofacial trauma, the treatment of secondary deformities, along with my aesthetic practice in cosmetic facial surgery.

After being in private practice for almost 20 years, my views have changed. I have come to realize that the ASMS represents those in practice as well as academic surgeons, who have a common interest in maxillofacial, craniofacial or facial cosmetic and reconstructive surgery. And this is what the ASMS means to me and what support it provides to private practice plastic surgeons.

1. The ASMS is a portal for education, conversation and debate concerning issues which regularly arise in plastic surgery and which are all common to all of us.

2. The ASMS is an advocacy organization representing its members concerning competing non-surgical organizations who are practicing facial cosmetic surgery outside of their scope of practice.

3. The ASMS provides support to its members on issues and problems in our day to day practice, whether coding or business issues along with surgical case problems.

4. The ASMS allows the individual plastic surgeon to be part of an historic organization and continue the “art” of cranio-maxillofacial surgery, while so many others have abandoned the specialty and are performing only cosmetic procedures.

5. The ASMS allows me, as a private solo surgeon, to access the wealth of knowledge available to many senior and junior members within the organization, without fear of embarrassment of inferiority.

As a member of the ASMS Membership Committee, I know how difficult it can be to convince surgeons who do not have an interest in maxillofacial surgery, to join ASMS. In these financially challenging times, we realize that all professional societies are competing for the same “annual dues” and members. More that just convincing new surgeons to join, I feel that our mission should be to maintain our active members and get them involved in ASMS activities. If a member does not pay their annual dues, we need to know why. And it’s not enough to send an email, we need to invite and welcome all craniofacial fellows to be active participants.

I am sure there are other plastic surgeons who might feel as I did in the past. We need to personally reach out to plastic surgeons within our communities who might be interested in membership and welcome them into our Society. We need to be inclusive, not exclusive!

Watch the ASMS website (www.maxface.org) as it grows into a valuable resource for ASMS Members, medical professionals, and patients.

New Features include:
- Enhanced Members Only Area
- Easier Navigation, including site search
- Educational Calendar and Upcoming Programs
Facial feminization surgery is perhaps one of the least understood subspecialties within plastic surgery. Relatively few plastic surgeons have dedicated the majority of their practice to this specific discipline. Moreover, the social stigmata of the transgender patient, unfortunately makes a true understanding of this field even more elusive. This text, authored by one of the world’s leading authorities on the subject, provides significant insight into this unique area within our specialty. The book was written as a guide for transgender individuals who might be seeking facial feminization surgery (FFS). The themes and content, however, are appropriate for medical professionals of all levels. Dr. Ousterhout's approach to patient care and patient counseling serve as an example from which both patient and practitioner can learn.

The text is divided into 14 chapters. The first provides a general overview of the surgical techniques used in FFS while the second reveals the author's approach to presurgical consultation. As one might imagine, counseling someone about an elective procedure that is geared toward total identity transformation is a daunting task. While many of our patients are concerned about how beautiful they will look after cosmetic facial surgery, FFS patients undeniably have unique concerns about their surgical outcomes. Reading the author's approach to this challenge is quite informative. Each subsequent chapter describes one of the individual techniques used in FFS. These include scalp advancement, forehead reconstruction, temporal fossa augmentation, rhinoplasty, lip augmentation, genioplasty, mandibular angle reduction, orthognathic surgery, thyroid cartilage reduction, and other associated procedures. Photographs of representative cases, sometimes striking, as well as schematic diagrams and radiographs complement the descriptions in the text.

Of particular interest to potential patients and to surgeons is the dialog the author has with his patients regarding surgeon selection. He advises all his patients to research the surgeon's training - make sure they are board certified; confirm they have specialty training and experience in craniofacial surgery; and be aware of the problematic issues associated with medical tourism. These are fundamental principles we would discuss with anyone presenting for consultation. As other specialists with variable levels of training encroach upon the specialty, reinforcing these principles becomes all the more important.

Facial feminization surgery involves the combination of a variety of basic craniofacial techniques and aesthetic procedures in order to change a masculine appearing face into a more feminine face. Perhaps in no other realm of plastic surgery is it truer that the sum of these procedures is greater than any of the individual parts. Yet while the specific goal of FFS may be unique, the author’s success is rooted in basic tenets of surgery: preparation, planning, and execution. Prior to tackling his first case, Dr. Ousterhout studied five texts on facial physical anthropology and then examined some 2000 skulls differentiated by their gender. His description of planning emphasizes the importance of cultural norms of beauty, balance, and how these norms vary between genders. As for execution, he emphasizes the importance of specific training in craniofacial surgery in order to master the technical skill required to manipulate the craniofacial skeleton, and appreciate how skeleton and soft tissue relate to one another in creating the concept of “beauty.”

Over the past three decades Dr. Ousterhout has performed over 5000 primary facial feminization surgeries. With this unique text he provides us with in depth exposure to a segment of the plastic surgery patient population that many of us will never directly encounter. He has taken the concepts set forth in his myriad peer-reviewed publications and summarized his approach to transgender patients by focusing on principles of care that can be applied to any endeavor in plastic surgery. The language used is appropriate not only for patients, but also for practitioners of all levels of experience, and the remarkable images shown are clear evidence of the author’s mastery of his craft.
Case Study: 18 year old Male with Orbital Dystopia after Blast Injury to Face

Craig Birgfeld, MD
Hospital of University of Pennsylvania

History
An 18 year old male who sustained significant facial and orthopedic trauma when a homemade pipe bomb detonated in his face and was airlifted to Harborview Medical Center where he was stabilized. He underwent bilateral lower extremity amputation, upper extremity repair, and endoscopic repair of frontal sinus fracture to treat CSF rhinorrhea. The otolaryngology service elected not to treat his facial fractures acutely.

The patient presented to the ophthalmology service after discharge from the hospital with findings of right traumatic optic neuropathy and vertical orbital dystopia secondary to unrepaired circumferential orbital fractures. At this time the patient reported new onset of “light flashes” in the right eye and was referred to the craniofacial service, as it was felt that should he regain vision in his right eye, he would suffer from significant vertical diplopia.

Physical Exam
The patient is a well-appearing 18 year old farmer. He has a coronal incision scar and stellate scars to his forehead, glabella and right upper and lower eyelids which are still maturing. His brow position is symmetric. His lid position is normal without scleral show or ectropion.

The patient has right mydriasis, hypoglobus, exotropia, and enophthalmos. He displays traumatic hypertelorism with a widened intercanthal distance. EOMI without entrapment. Vision: He cannot discern fingers on the right. The patient displays right malar flattening and widening. His nasal airway is patent bilaterally. His occlusion is Class I. He has mandibular opening of 4 cm. Cranial nerve VII is intact throughout all branches bilaterally. He has decreased sensibility to light touch in the V1 and V2 distribution on the right.

Radiographs
Maxillofacial CT scan with axial, coronal and 3-dimensional reconstructions displays healed fractures. There is evidence of displaced, bilateral Naso-Orbital-Ethmoid fractures, displaced right zygomaticomaxillary complex fracture, right orbital floor and orbital roof fracture with orbital roof defects. There is partial healing of anterior table frontal sinus fracture and healed frontal bone cranial fractures.

Assessment
Right orbital dystopia secondary to unrepaired, displaced fractures of the right orbit. Specifically an inferiorly displaced orbital roof, a laterally displaced medial orbital wall and naso-orbital-ethmoid complex, and inferio-laterally displaced right zygomaticomaxillary complex with inferiorly displaced orbital floor fracture.

Medical decisions
1. Do nothing as it is unlikely he will regain vision, but will have to live with his deformity.
2. Improve his globe position with extraconal implants and camouflage his malar flattening with MedPor malar implant.
3. Perform subcranial repositioning of his zygomaticomaxillary complex and repair his orbital floor defect.
4. Perform transcranial orbital repositioning with reconstruction of orbital roof and orbital floor defects.

Procedure
The patient was approached through the previous coronal incision and a mid-lid lower eyelid incision. A craniotomy was performed and the orbital roof was elevated and reconstructed with a split calvarial bone graft. The zygomaticomaxillary complex was osteotimized and repositioned anteriorly by 5 mm and superiorly by 1.5 cm. Osteotomies were performed around the right medial canthal tendon and the NOE complex on the right was moved medially and fixated with a transnasal medial canthopexy wire.

The orbital floor was reconstructed with a split clavarial bone graft. A lateral canthopexy was performed.

Note: A key component to this case was not only recognizing the previous unrepaird, displaced fractures, but the significant contribution the displaced orbital roof makes to the orbital dystopia. I do not think that any reconstruction would have been successful without addressing the inferiorly displaced orbital roof fracture.
Differences in the Practice of Plastic Surgery
North and South of the Border: A 30,000 Foot Perspective

Jugpal S. Arneja, MD, FRCSC
Wayne State University

To dovetail with the most recent ASPS/ASMS/PSEF meeting in Canada, an appraisal of the differences between the health care systems of the United States and Canada is presented. ASMS Members attending the recent meeting in Toronto experienced a dollar at parity, polite Canadian hospitality, as well as regular reminders that both of our nations are at the zenith of hockey supremacy! Although cleft lip repair or mandible fracture fixation techniques may be identical for patients operated on in Toronto or New York, striking differences are present north and south of the 49th parallel in the delivery of health care services.

I have had the distinct pleasure of experiencing both medical systems through the completion of my residency training in Canada, with subsequent fellowship in the United States, followed by being a junior faculty member and beginning my clinical practice for four years in the United States. I have since returned to Canada and for the past 18 months have experienced not only the delights, but also the frustrations of both systems. The present report will outline practical differences found in the practice of reconstructive plastic surgery in both systems as well as insight as to where the future of healthcare in both countries may be headed. Of course, in self pay aesthetic patient care scenarios, both health systems operate in a parallel fashion.

Healthcare in Canada

Proud politicians in Canada will tout the universality associated with the Canadian health care system, where every resident has the ability to access the health care system; however this feature contrasts with difficulties in health care access for the public given geography, as well as lengthy waitlists for elective diagnostics and interventions. Patients have resigned to the fact that they may wait several months for a specialist appointment, specialized diagnostics, and elective surgery. Given the per capita dearth of physicians and medical centers in Canada, there is virtually no competition in the health care system for patients and within a few weeks of a new surgeon’s practice initiation, their clinics are full and a waitlist is usually initiated for surgery.

On the insurance payment end, there is essentially a single payor (the provincial government), which sets fee tariffs and although reimbursements may be lower for the same procedure as compared to the United States, surgeons’ are reimbursed in a consistent and reliable manner. Upon analysis of malpractice insurance, a nationwide not-for-profit insurer, the Canadian Medical Protective Agency insures the great majority of Canadian doctors. Annual costs are a fraction of the costs associated with insurance in the United States. The 2011 average malpractice cost for a Canadian Plastic Surgeon is $9000.

Healthcare in the United States

The first element of health care delivery to strike me while working in the United States was how complicated the insurance system was as it pertained to pre-authorization, claims/reimbursements, coverage networks, and the fact that medical decisions for treatment were not always made by physicians. Furthermore, at each level of assessment and treatment, medicolegal ramifications would be raised as a concern regarding which route to take. This undoubtedly was a result of a high prevalence of malpractice claims and to offset this fact, high malpractice insurance rates.

For patients, the system does offer several advantages including more plastic surgeons, more hospitals, closer patient proximity to medical care, plentiful resources with limited wait times for diagnostics and treatment; patients expect timely care and are more often than not well-informed consumers. As a trade off to the plethora of resource is competition for patients; although seemingly an obstacle, competition does provide an incentive for constant re-evaluation and improvements in care delivery. In fact, for a variety of reasons, plastic surgical care in the United States has become superspecialized; surgeons focusing their expertise to a particular clinical realm has become the norm as compared to a more generalized practice profile in Canada.

Conclusion

With the Obama Administration having arrived at a mandate for health care reform in the United States in an effort to achieve universal accessibility, and with the most glaring limitation in the Canadian system being timely access to health care, the future of health care delivery in North America could be a blend of the two systems. Without question, an obvious advantage of the Canadian system is the low malpractice cost which is a direct correlation to the non-litigious nature of Canadians. Furthermore, and perhaps more importantly, frivolous lawsuits are essentially nonexistent in Canada given the stringent tort laws preventing such claims. Clearly, costs associated with health care in the United States could be circumvented with tort reform. Both systems do have clear advantages and limitations, confirming the fact that surgery itself is often the easiest component of patient care, while navigating the system often produces the greatest challenge.
The ASMS Research Grants are awarded annually for proposals that address all aspects of research in craniomaxillofacial research. Previous experience is not necessary, however, residents and fellows require a letter of support from an ASMS sponsor. The number of awards granted is determined by the Research Committee, based on the quality and quantity of proposals received.

The following is a dialogue with Guy Cappuccino, MD, a recent recipient of the ASMS Merck Research Grant.

**ASMS News:** What project did you do for the ASMS Merck Grant?

**Cappuccino:** I looked at various uses of dermal regeneration matrices in craniomaxillofacial reconstruction. We found particular utility in total scalp avulsion with exposed skull.

**ASMS News:** How did the Merck grant help you?

**Cappuccino:** The Merck grant helped me purchase a comprehensive plastic surgery textbook series that I would not have been able to afford on my resident's salary.

**ASMS News:** What did you like about the Merck grant program?

**Cappuccino:** The opportunity to meet and collaborate with nationally renowned maxillofacial surgeons.

**ASMS News:** What advice would you give to plastic surgeons considering applying for it?

**Cappuccino:** Think about the types of cases you seen in your practice/ training program. Find a particular problem or a new technology/ product in which you are interested and go from there. The best advice I can give any young surgeon is to do what you enjoy. Satisfaction is sure to follow.

If you are interested in applying for an ASMS Research Grant, please contact the Administrative Office, 978-927-8330.
It was with a sense of great expectation and anticipation that I stepped out of the main train station at Bruges, Belgium for the XX European Association Craniomaxillofacial Surgery (EACMFS) Congress beginning the following morning on September 14, 2010. The aim of this prestigious biennial event was to cover not only the important theoretical and clinical aspects of this challenging field of surgery, but to also offer delegates the opportunity to interact with the faculty. Master classes were selected according to the feedback obtained from participants at the last EACMFS Congress in Bologna, Italy. As one would expect from Professor Mommaerts and the Organizing Committee, ethical and clinical standards were high. Approval for the course had been obtained from both the USME and EACMF.

Bruges is a medieval walled city with wonderful architecture and meandering canals. It has often been described as “the Venice of the north.” Careful city planning with an emphasis on conservation has meant that the city has not undergone the huge expansion that is often associated with historic European cities. Bruges enjoys world class amenities and facilities, such as a dedicated conference centre, all within walking distance.

Ultra Plus, the theme of the Congress, focused not only on the facial deformity of Charles V but looked beyond his appearance into the man himself. Achieving unity amongst the people of Europe was his paramount concern. The work of the EACMFS very much embodies the spirit of partnership and cooperation between the different European countries. Indeed, the reach of the 2010 Congress extends far beyond Europe.

The diversity of the guest societies present at the Bruges meeting reflected, not only the international flavor of the meeting but also, the close relationships that exists between EACMFS and other societies. The bonds between EACMFS and ASMS seem to strengthen with time, as the two organizations share a similar vision of promoting surgical excellence through educational programs and scholarships to aspiring surgeons.

Professor Mimi Cohen, current ASMS President, reminded EACMFS delegates that this was the 3rd consecutive EACMFS Congress in which the ASMS had presented an ASMS Guest Society Symposium. He warmly invited everyone to the ASMS Guest Symposium, as well as to the 2010 ASMS day in Toronto, Canada. Last year ASMS invited Professor Hugo Obwegeser to Chicago to deliver the prestigious Converse lecture.

The ASMS fellows knew they had a reputation to live up to as the standard set in Bologna was high. Although the temptation to sample Belgium fries, gulp down oysters and sample the very best of Belgium cuisine always beckoned, it was never going to satisfy the intellectual appetite of ASMS delegates. They wanted a piece of the action! ASMS fellows not only contributed to the ASMS guest symposium, but to many different sessions of the Congress. Below are just some of the highlights.

Cleft & Craniofacial Symposium

A thought provoking paper addressing the lack of expected neurodevelopment that can occur in some patients after surgery for craniosynostosis was delivered by ASMS fellow, Dr. V. Singhal. He found that in some patients, head circumference (HC) failed to follow the expected cranial growth after surgery. In this group of patients there was both persistently raised intracranial pressure and decline in neurodevelopment. Surgical intervention (revision surgery) appeared not only to reverse their symptoms of increase intracranial pressure but also allowed for normal neurological and intellectual development.

A German group reported their experience with the use of helmet therapy to treat positional plagiocephaly. They found that the ideal time to start treatment was at 6 months and that most improvement was seen within the first months of treatment. A helmet was worn for 23 hours a day. The team also presented their work using calipers to measure head circumference.

Dr. Andrew Wexler commented on the US experience with an apparent epidemic of plagiocephaly which followed the “back to sleep” campaign (a public health initiative directed at preventing sudden infant death). He said that orthoptists in the USA had on site scanners to measure HC rather than calipers.

Dr. Wexler advised that the expense associated with helmet therapy can be avoided by offering advice to parents about the correct positioning of their child when sleeping.

Dr. Jong Woo Choi from Korea used axial CT scans to measure skull base axis deviation from the midline in plagiocephaly patients. His study found that distraction osteogenesis improved skull base angulation more than advancement osteotomies.

An interesting paper addressing the classification of Pfeiffer Craniosynostosis was delivered by Dr. Aina Greig from New York University (NYU). Unlike the 1993 Cohen classification, which focuses on the sutures affected, the group from NYU developed a functional classification based on the respiratory, ocular, otological, and neurological co-morbidities present. They found that a functional classification was more helpful in determining the severity of the phenotype.

The work of the EACMFS very much embodies the spirit of partnership and cooperation between the different European countries. Indeed, the reach of the 2010 Congress extends far beyond Europe.

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Bruges 2010  *(continued from previous page)*
and in selecting those patients for whom multidisciplinary care and intervention would be beneficial.

**ASMS Guest Symposium**

The much awaited ASMS session was well attended. As was to be expected, it was more than just an educational session; it was a meeting of friends. Many of the assembled delegates were beneficiaries of a transatlantic relationship going back many years.

**Anatomy of a Smile**

The first speaker was Dr. Andrew Wexler, presenting “Anatomy of a Smile.” Dr. Wexler mentioned that smiling is a universal language. It is a gesture or an expression that cuts across language and social barriers. He remarked that it was important for social interaction, making new friends and success at work. He felt that a smile is a great leveler. Indeed, Dr. Wexler was in his element whilst giving this lecture, frequently smiling at his captive audience.

The different types of smiles - the sneer, the Cheshire cat smile and the sardonic smile were all outlined. Dr. Wexler gave clues to how one can detect a false smile. He remarked that a natural smile will produce wrinkles at the corner of the eyes. He advised caution when administering Botox to eliminate ‘crow feet wrinkles’ in this region.

A smile has both hard and soft tissue components. The alignment of teeth can have an impact on a person’s smile. The arc of the lower teeth should mirror the curve of the lower lip. Dr. Wexler also outlined the universality of the ‘Golden Mean’, an aesthetic index not only seen in ancient architecture and nature but also represented in the anatomy of a beautiful smile. Respect for the laws and rules governing facial harmony was also addressed.

Finally, Dr. Wexler stressed that although aesthetic goals are important, one should not lose focus on what the patient actually wants. The value of listening to patients and prioritizing treatment according to their needs should always be paramount.

**Neonatal and infant Mandibular Distraction for Sleep Apnea**

Dr. Mark Urata from Children’s Hospital, Los Angeles was the next ASMS fellow. His presentation dealt with sleep apnea, one of a multitude of difficulties that can occur in neonates and infants born with a compromised airway as a result of micrognathia. Poor language development and feeding difficulties are just a few of the serious concerns facing the maxillofacial surgeon. At UCLA, sleep apnea is managed by a multidisciplinary team consisting of a neonatologist, a sleep specialist, and a maxillofacial surgeon.

Although conventional treatment of this challenging group of patients consists of positioning the infant prone, giving supplemental oxygen and tracheostomy (gold standard), for some patients this mode of treatment is not without problems. For example, the morbidity associated with tracheostomy can be between 5 and 70%.

The integration of the affected child into the community can also be problematic. The “burden of disease” is not just physical and psychological but also financial. Medical expenses add to the cost of a parent having to give up work to care for a child.

Both clinicians and family members have looked at other options such as distraction osteogenesis (DO) of the mandible. Indeed, some parents may be forced to make this choice in order to facilitate early rehabilitation of their child into the community, despite knowing that given time, normal mandibular growth without surgical intervention may overcome some of the respiratory problems.

However, mandibular distraction is not done in those neonates with respiratory distress as a result of subglottis stenosis, central sleep apnea and severe oesophageal reflex.

At UCLA, some infants with hemifacial microsomia (HMF) are treated with distraction osteogenesis to facilitate their discharge from hospital as certain key stakeholders in the community will not accept such patients unless they are in a “safe condition”.

Infants with Pierre Robin Sequence (PRS) can also benefit from DO. Dr. Urata described such a patient with a history of recurrent episodes of cyanosis for whom, distraction of the mandible relieved the child of such distress. Improvement in quality of life and the comfort that parents gain from such intervention are clearly palpable. With so many delegates working in different health care models and having exposure to different schools of maxillofacial surgery it was not surprising...

*contribution made by ASMS to the successful Bruges Congress once again confirmed its position as a body dedicated to enhancing and improving people’s lives through the promotion of maxillofacial surgery both in America and the world.*

(l. to r.) Joe Muhammad, Mark Urata, Luigi Clauser, Mimis Cohen and Andrew Wexler

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that the presentation gave rise to an active debate.

Dr. Joachim Obwegeser (ASMS International Member, Switzerland) commented that although the aim for distraction in PRS is to avoid tracheostomy it is important to inform parents of children undergoing DO that further surgery will probably be needed to correct any residual skeletal deformity.

The technique described by Dr. Urata employed an external approach using a modified Risdon incision. An inverted “L” shape mandibular osteotomy was done. Twenty-four hours later (latency period) distraction was commenced. The consolidation period was 3 months. In the series presented, 21.3mm was the mean distance that the mandible was distracted.

Functional and Aesthetic Correction of Residual Cleft Nasal Deformities

Dr. Mimis Cohen gave a brief history of the primary correction of the nose in cleft nasal deformity. He mentioned that Dr. Tord Skoog abandoned this procedure along with primary perioplasty in 1969. It was not until Dr. Harold McComb in 1985 demonstrated that primary correction of the nose had no detrimental effects on nasal growth did the technique gain more acceptance. Similar results were obtained by Dr. Salyer in 1986. Dr. Cohen reminded the audience that the University of Chicago introduced many innovations for cleft surgery such as naso alveolar moulding (NAM).

He emphasized that reconstructive goals of secondary cleft deformity should also include improvement in the function and quality of life of the patient. For example, pain and sinusitis arising from a persistent palatal fistula can be treated by surgical repair of the fistula.

The use of rhinomanometry for cleft patients as an objective method to measure airway resistance was highlighted. In a philosophical mood, Dr. Cohen said that only through looking at our numbers can we learn from our results. If one does not see the problem how can one find the answer?

Dr. Cohen prefers to do a turbinate reduction rather than turbiectomy. Dr. Gundlach (ASMS International Member, Germany) asked Dr. Cohen about repositioning the deviated septum in the midline first and then waiting for the turbinate to reduce in size. Dr. Cohen responded that there was no clear proof that the cause of the hypertrophied turbinate was due to mucosal thickening. He did stress that the reduction of an enlarged turbinate was important to facilitate nasal endoscopy. A discussion ensued relating to the merits of radiofrequency ablation over laser ablation to treat hypertrophied turbinate.

Dr. Cohen sees new ways in which cleft deformity could be graphically represented as a future avenue for development. Indeed, a move from 2 dimensional to 3 dimensional representation of cleft anatomy has been discussed at this meeting (Dr. Gosia Reddy, ASMS International Member, India)

Openness & Honesty in Surgery: Sharing Mistakes

Finally, Dr. Cohen mentioned that it was very important to share our mistakes with others so that colleagues and trainees can learn from them. Openness and honesty, with a touch of vulnerability, can allow trainees and fellow surgeons to manage some of their own private emotions, especially when one has to cope with some of the lows that can be associated with surgical practice.

Admiration is the only term applicable to describe the candid and frank manner in which Professor Hugo Obwegeser shared his first experience with the bilateral mandibular sagittal split osteotomy. Initially, the operation did not appear to go well. The patient was swollen and the young Dr. Obwegeser was concerned that his boss would not see the merits of his new procedure. In his moment of despair, when things seemed lost, he prayed to his Lord for assistance. The rest is history.

Drs. Mommarts, Sailer and Farmand honored Dr Hugo Obwegeser and expressed their gratitude for the gift of knowledge he bestowed on them. It was a wonderful example to the younger generation of respect and humility from three highly successful and respected surgeons. We have seen the same respect for surgical giants such as Dr. Paul Tessier, Dr. Ralph Millard and Dr. John Converse from ASMS fellows Dr. Henry Kawamoto and Dr. Tony Wolfe.

Sharing knowledge is unlike sharing money as the original capital never decreases no matter how much it is shared. The return on this type of investment multiplies many times. It is seen in both the continuity of highly specialized care to our patients and the dissemination of knowledge to other parts of the world.

The selfless contribution made by ASMS to the successful Bruges Congress once again confirmed its position as a body dedicated to enhancing and improving people’s lives through the promotion of maxillofacial surgery both in America and the world.
the responsibility of coordinating and arranging the 2011 meeting in Denver and I encourage you to contact him with any ideas or suggestions that you would like to incorporate into the upcoming program.

As we start the New Year there are many exciting changes and challenges that face our Society and with the immense help of our new Board of Trustees, the new committee chairman, and the active participation of all committee members, we plan on getting off to a fast start. Perhaps the most significant change to contend with is on the operational side of the Society. I have recently signed a contract with PRRI to become the new management company for the ASMS. We have already begun the process of transitioning from the previous administrative assistance under the ASPS to PRRI and we are excited to reap the benefits of many of the advantages they will bring to our membership. Aurelie Alger, JD, PRRI President, and Stanley Alger, the new ASMS Executive Director, have both committed themselves personally to the seamless transition of the management of our Society and they have started working on helping us to serve our members with greater efficiency and in a more user friendly manner.

Over the next year you will notice a significant upgrading of our website (www.maxface.org) and we hope to have all of you regularly utilize our improved web presence as a value added feature. I trust that these enhancements will allow our members to take better advantage of all of the ASMS programs and offerings going forward. Dr. Joseph Losee is spearheading our efforts as chair of the Website Committee and would be open to ideas or to those of you that would like to help in this transformative process.

In the long tradition of educational excellence, the ASMS continues to offer two basic courses each year and this coming February 19 and 20th we are organizing an Advanced Maxillofacial Course that is intended for the significant portion of our membership that are practicing plastic and reconstructive surgeons.

In the challenging economic times in which we find ourselves, the ASMS is constantly looking for partnerships with our sponsors that help to create new opportunities for our members. I ask you to show the same loyalty to those that have helped to sponsor our programs as they have shown to our organization. I am happy to add Osteomed to our established circle of benefactors committed to the ASMS and it’s educational, clinical, and research mission. They have pledged their support to allow us to continue our resident/fellows scholar program. In addition, they will take on the main sponsorship of one of our Basic Courses. On behalf of all of our membership: Welcome aboard.

I would like to you that membership is the life blood of any organization and the ASMS is no different. Our Membership Committee, under the direction of Dr. William Hoffman, will be working diligently over the coming year to increase the numbers in our ranks. He can use your help and I would you to seek out just one individual that you would like to sponsor as a new member and make that happen. We will do our part by attempting to streamline and automate the process. If you have an individual that you would like to sponsor just contact us via e-mail, phone, or website and help us to enrich and expand our organization in order to invigorate and nourish our Society with new ideas and a fresh supply of boundless energy.

Again, I want to thank you for this great opportunity to lead the ASMS through the challenges and opportunities that lie ahead. I will work conscientiously to lessen the barriers between the leadership of our organization and you, the members. I can always use your help and would ask any and all of you that would like to get involved and participate, to do so. Just write me with any ideas or let me know of any desire you might have to become engaged in the process. I look to the voice of the membership to assist me in setting our priorities for the future. As 2010 comes to a close, I want to wish all of you a happy and a healthy new year.
addition to the hard effort necessary to become a good doctor, my life as a surgeon would be difficult and demanding – requiring not only many years of study and training and long hours of practice and dedication to my patients, but also continuous updates to my learning and education.

In the most recent years, and many centuries after Hippocrates’ remarks, we realize more than ever the importance and need for continuing education, so the concept of maintenance of certification has evolved and is becoming an integral part of our lives.

The ASMS mission is to advance the science and practice of surgery of the facial region and craniofacial skeleton. The Society accomplishes its mission through excellence in education and research, and through advocacy on behalf of patients and practitioners.

For the past 63 years, ASMS has made the commitment to maxillofacial education the cornerstone of its very existence. During that time, we’ve developed many wonderful courses and have trained and updated a great number of residents and practicing surgeons, providing them with cutting-edge knowledge and experience in the craniofacial surgery field.

We also actively participate in several maintenance of certification activities by working closely with the American Board of Plastic Surgery, and recently we’ve joined forces with ASPS/PSEF to provide craniofacial-related material for the new Plastic Surgery Education Network, an online educational portal due to launch in early 2011.

Our flagship and the course we’re best known for is the ASMS Basic Maxillofacial Course, which has been offered every year for the past 34 years. It’s one of the oldest courses in plastic surgery, attended annually by more 100 surgeons.

But ASMS has created and continues to offer several other great educational programs, including ASMS Day and the pre-symposium conference here at Plastic Surgery 2010; the advanced maxillofacial course; and most recently, the Plastic Surgery Hyperguide (plasticsurgery.hyperguide.com) and the ASMS Visiting Professor Program.

Plastic surgeons have traditionally participated in missions around the world to provide care for underprivileged patients. In an effort to provide surgeons interested in such volunteer activities with in-depth information about the surgeries and the complex issues related to such endeavors, we designed a new multidisciplinary course titled “Challenges in Cleft Surgery in Underdeveloped Nations.” This exciting course, endorsed by several sister societies and the American Academy of Pediatrics, will be held Jan. 16 in Miami.

Finally, we’re reaching out to our European colleagues in this time of global community – endorsing their annual meetings and other courses – and actively participating in their programs.

This is an exciting, new area of collaboration and we’re looking forward to further cooperation with fruitful and productive outcomes.

As you can imagine, all these activities require significant efforts and dedication on behalf of the ASMS Board of Directors – and substantial funds as well. We’re thankful to our members who provide us with their financial support, and grateful to our industry sponsors who trust and believe in us. They have partnered with us for several years and generously fund our programs. We couldn’t continue without their support.

We’re living in challenging times, with an unstable economy and major changes to the health care system. Thanks to new health care legislation, millions of uninsured Americans will now receive some form of coverage, and insurance carriers will no longer be able to deny coverage with the excuse of pre-existing conditions – something that plastic surgeons had fought for years.

It was an unfair, irrational and, yes, immoral practice that affected the care of many patients, especially impacting the lives of children born with clefts and other craniofacial anomalies, who needed several reconstructive procedures from birth to adulthood to complete their treatment.

Health insurance reform could have been very good news and a reason to rejoice. Unfortunately, most states face serious economic problems, so they delay reimbursement for rendered services by many months. But that reimbursement turns out to be very low and out of touch with the amount of time and effort spent on our procedures. Still, we continue to provide care and constantly strive to improve the techniques and procedures available for our patients.

Another related area of major concern is the growing control and power that the government, insurance companies and hospitals are gaining over the practicing physicians. Policies are established without our participation, decisions for care are made based not necessarily on the best interest of our patients, and reimbursement is fixed.

We’re no longer called physi-
President Cohen  (continued from previous page)

cians, but “providers.” Yes, providers! This is definitely not what Hippocrates had in mind for the newly created noble and respected medical profession, when he advised his disciples as doctors to become friends of the healthy and fathers of the sick. This is not what you and I had in mind when we entered medical school. But things are changing, and we must act now to have a voice in that change.

Despite our differences, we must stick together with all organized physician groups and develop creative suggestions and solutions. Don’t expect a small group of your Society leaders to solve all your problems. Each of you must become more involved and vigilant to make your voice heard.

It is worthwhile. I am very optimistic by nature, so I can’t close on a pessimistic note.

Despite all these major problems, we cannot – and should not – lose hope. Medicine is a profession, but also a mission. Our patients depend on us more than ever, and we can’t disappoint them. We are their hope!

It’s been my privilege and honor to serve as ASMS president. This has been an exciting and very productive year. Thanks to the vision, hard work and accomplishments of our previous leaders and the efforts of the ASMS board, we are financially stable; well established and appreciated by our peers; constantly expanding; and face the future with optimism.

I would like to express my deep appreciation to all our members and staff for their hard work and dedication to our organization, and for their constant support and advice.

Most of all, I would like to thank my wife, Andrea, and my daughter, Saranna, who have supported my career endeavors for all these years – and make my life complete.