MAXILLOFACIAL NEWS
American Society of Maxillofacial Surgeons
Summer/Fall 2010

Reflections from the President

Mimis Cohen, MD
University of IL, Chicago

By now, you have received the final program for Plastic Surgery 2010 in Toronto. I hope you agree with me that this is a superb program with many interesting lectures, panels, presentations, and experienced featured speakers. Congratulations to all members of the Scientific Program Committee and staff who worked so hard all these months and are still working to assure that our meeting will become a premier educational experience for all participants and plastic surgeons from North America and around the world as well.

Our **ASMS Day** will be Sunday, October 3 and will include craniomaxillofacial sessions with panels and free papers; the Converse Lecture given by Dr. Ian Jackson, titled The Management of Skull Base Tumors, ASMS Research Grant awards presentation; the ASMS Luncheon and Annual Business Meeting. The Presidential Reception will be held at the Club Lounge atop the Sheraton Centre Toronto, which offers spectacular views of the Toronto skyline.

Do not forget! Our Pre-Conference Symposium will be held on Thursday, September 30. Dr. Robert Havlik, our First Vice- President and Scientific Program Committee Chair, has prepared a program featuring great speakers and a variety of very interesting topics. The entire Scientific Program Committee deserves our thanks for their hard work. You can check out the complete program in the following pages of this publication.

The Basic Course took place in Chicago at Northwestern University August 13 -15. This course was supported by Biomet Microfixation. Dr. Warren Schubert, Chair of the Education Committee, continues to improve the course by organizing high quality programs thereby ensuring a superior learning experience for all participants. He needs to be congratulated for an outstanding job. The Winter Basic Course will be held at the University of Miami from the January 14-15, 2011. This course is supported by KLS-Martin, L.P. In addition, thanks to an educational grant from Stryker, we are planning a full day Cleft course on January 16, 2011. This course will immediately follow Basic Course. Dr. Seth Thaller will serve as Program Chair and Local Host.

A new course supported by Biomet Microfixation titled Advanced Multi-Specialty Course was offered in February 2010 for the first time. The multidisciplinary faculty offered specific lectures and participated in fresh cadaver dissections. Due to its success, the course will be offered again in February 2011. We hope it will become another great annual event sponsored and complete program information for these courses will be available in the Fall. These activities along with the Visiting Professor Program represent exceptional educational opportunities for residents and young practitioners. Program Directors should make a note and encourage their residents to attend. Finally, 15 plastic surgery residents and/or fellows will be sponsored again this year and given the opportunity to participate in the Pre-Conference Symposium and the annual meeting. We received a great number of nominations for the Resident Scholar Program which is generously supported by Biomet Microfixation. Dr. Andy Wexler and his committee will review the nominees and will announce the names of the Scholars.

ASMS recently agreed to participate in the Plastic Surgery Education Network (PSEN) web portal, along with other subspecialty societies. We are responsible for coordinating all craniofacial related submissions. Several board members have already agreed to assist me in this activity. But there is a lot of work to be done, including reviewing and selecting clinical education DVDs, In-Service Exam questions and journal articles. We will need further assistance with this task and I would like to invite all members interested in participating to contact me directly for further information and assignments.

We also recently signed an organizational alliance agreement with the American Cleft Palate-Craniofacial Association to enhance the exchange of information between care and service for our patients and consumers, and to coordinate advocacy efforts related to issues of mutual concern.

The 2009 financial audit/review has now been completed by the public accounting firm of Legacy Professionals LLP. The final results indicate that ASMS is financially sound and that our financial position has strengthened significantly from 2008. On another note, in June, our Treasurer, Dr. Henry Vasconez and members of the Finance Committee led by Dr. Kant Lin, worked diligently to develop the 2010 budget. In addition to this year's budget, for the first time, the Finance Committee developed a financial forecast for 2011 and 2012. Creating a 3-year financial forecast model, we believe will aid us to facilitate our operational and strategic decisions, thus allowing us to continue improving our finances and overall strengthen of our organization. Special thanks to Mark Espinosa from the ASMS office for his help, guidance, and financial advice during the last three months.

In summary, thanks to the membership and industry partner support ASMS stands strong in our commitment to education and presenting several unique and high quality programs each year. We would like to maintain ASMS as the leading craniofacial organization worldwide and I encourage all members to get involved, actively participate and help us achieve our goals.

Hope to see you all in Toronto.

Making ASMS More Relevant to its Membership: Member-Directed Initiatives and Member Participation in ASMS Committees

Steven Buchman, MD
University of Michigan

The year is flying by and it will not be long before we are all together at the national meeting in Toronto in early October. As President-Elect, I am already working on plans for the New Year and I wanted to gain worthwhile insight as to the needs and desires of the membership in order to prioritize the efforts of ASMS going forward. Although a broader-based questionnaire was sent to the membership a few years ago to gauge attitudes and opinions within the organization, I would like to focus much more on member-directed initiatives. Specifically, I will be sending an email through the ASMS Office asking each of our members: *"If you had the choice and were able to pick one particular initiative that ASMS could accomplish for the coming year, what would that be?"* I will use this valuable input from our membership to address the issues of greatest concern and to set an agenda that is relevant, desirous, and achievable during my term in office. If this "call to arms" inspires you to opine, do not feel like you have to wait for the email to arrive, just send me your answer directly at sbuchman@umich.edu or to Yolanda Amjad at the ASMS office yamjad@plasticsurgery.org. The idea of member directed initiatives, of course, relies on your participation and I hope to encourage an on-going dialogue to secure both your interest and attention.

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Editor's Column

Arun K. Gosain, MD
Case Western Reserve University

We are proud to present the most recent edition of the Maxillofacial News as we transition to an electronic format for subsequent editions. The Maxillofacial News represents the most current topics of relevance to craniomaxillofacial surgeons. In this venue, we wish to highlight the process of Maintenance of Certification® (MOC) as it pertains to the maxillofacial surgeon. MOC will continue to move forward in all specialties of medicine. To highlight the importance of this process, I wish to address the following issues:

1. Why should plastic surgeons participate in Maintenance of Certification?

Maintenance of Certification® is a process that has been developed by all 24 medical specialty boards of the American Board of Medical Specialties (ABMS), and plastic surgery has been the leader with its Maintenance of Certification in Plastic Surgery program (MOC-PS®). The value of this process for the medical specialties is that it is a way to demonstrate to consumers of health care (patients) and third party payers of health care (private insurance carriers and government sponsors) that those certified in that specialty have remained current in practice. It is to the advantage of the respective medical boards that they retain the ability to demonstrate that individuals they have certified are current in their area of board specialization. Were the medical boards not to serve as leaders in this process, then there would be a need to demonstrate that physicians are current in the practice of medicine in general, irrespective of their area of expertise. This would translate into a recertification process that would include such questions as care of diabetes, reading of EKG's, etc. Certainly, this would not be to the advantage of physicians who are board certified in plastic surgery.

2. Why participate in Maintenance of Certification if one holds a Lifetime Certificate by the American Board of Plastic Surgery?

There is a demand for transparency in medicine by government agencies, private insurance carriers, and patients. These parties are increasingly aware of the value of Maintenance of Certification by health care providers. Several medical specialty boards have recently adapted requirements in response to the increasing demand for lifelong Maintenance of Certification. The American Board of Surgery now requires ABMS MOC participation of all lifetime certificate holders. The American Board of Pediatrics has implemented a "continuous certification" program this year for all diplomates. To maintain accreditation, hospitals may also need to demonstrate that physicians who have privileges at their institutions are engaged in a process of ongoing Maintenance of Certification. Therefore, no physician will remain immune to this pressure. If the individual medical specialty boards simply counter that their diplomates have been certified for life, then other organizations or quality groups will be pressured to assume responsibility for Maintenance of Certification for all physicians irrespective of specialty. This would again entail a general examination in medicine that would not be to the advantage of plastic surgeons, and even less so for those whose practice is focused on one area of plastic surgery such as maxillofacial surgeons. Therefore, it is in the best interest of the specialty if all of its members participate in Maintenance of Certification.

3. What are the components of Maintenance of Certification?

Maintenance of Certification consists of:

1. A professionalism component which incorporates Continuing Medical Education requirements
2. A written examination taken once every 10 years. The focus of the exam can be in one of four modules (Comprehensive, Hand, Cosmetic, or Craniomaxillofacial);
3. A Practice Assessment module submitted every 3 years. Five practice modules are available for each of the four core categories of plastic surgery. The core categories available in Craniomaxillofacial surgery are listed in the following section.

4. What has been the participation of maxillofacial surgeons in the respective specialty modules?

Since 2008, 1,739 plastic surgeons have participated in the Practice Assessment component of Maintenance of Certification. Of these surgeons, only 75 (4.3%) have participated in one of the five tracer modules developed for craniomaxillofacial surgery. The following table demonstrates participation in the four module groups to date, and specific participation in the craniomaxillofacial modules.

Module Group	Number Participants	% Total
Cosmetic	797	45.8
Comprehensive	692	39.8
Hand	175	10.1
Caniomaxillofacial	75	4.3
Craniomaxillofacial Module		
Cleft Palate (Primary)	56	3.22
Non-Syndromal Craniosynostosis	10	0.58
Zygomatic Fractures	7	0.4
Secondary Cleft Nasal Deformity	2	0.12
Genioplasty / Chin Implant	0	0

5. How can maxillofacial surgeons improve the process of Maintenance of Certification specific to their needs?

Due to the limited participation in craniomaxillofacial modules to date, we are not able to provide a reliable sample of the activities of craniomaxillofacial surgeons. Presently, ASMS has 320 Active and 92 Life members. Therefore, only a small minority (75 surgeons) have participated in the Craniomaxillofacial MOC tracer modules to date. We clearly need increased participation in these modules by ASMS members in order to provide valid data regarding the efficacy of the modules. The fact that no surgeon has chosen to utilize the genioplasty module and only 2 surgeons have chosen to use the secondary cleft nasal deformity module does not allow the American Board of Plastic Surgery (ABPS) to make any valid conclusions from these modules. In order to maintain the validity of the process, our members must utilize the resources available to them. This begins by increasing participation in the MOC process. In addition, I encourage those ASMS members who do participate in the process to utilize one of the craniomaxillofacial modules that have been developed. Should our members choose to use another set of modules, such as cosmetic, then it will be difficult to improve the process of data collection for MOC specific to maxillofacial surgeons. The Craniomaxillofacial (CMF) Advisory Council members to the ABPS used data from the early Recertification program case collection content to recommend and then develop the current five CMF tracer modules for MOC-PS. In addition, the ABPS is looking at other modules that may be more relevant to our membership. However, regardless of how much effort the ABPS puts into the MOC process, it is the effort of our members to participate in the maxillofacial component of MOC that will strengthen the process. Eventually, this effort will help to strengthen our specialty and insure that we remain in control of Maintenance of Certification. This is far preferable to a body outside of the ABPS taking control of this process.

Making ASMS More Relevant

Continued from page 1

For those of you willing to give more of your time, the Board and I eagerly welcome involvement and contributions by anyone in our membership that is interested to do so. We have refined the committee and governance structure over the past few years to eschew redundant and gratuitous committee work, with an eye to making any time that is given to our organization more productive and fruitful. As I prepare to assign members to committees for the 2010-2011 year, I ask you to let me know which of the committees you have an interest in and if you would have the time, effort, and inclination to take on a leadership role. For the new and young members in the society, I ask you to seriously consider getting involved; hard work and accomplishments in our organization are rewarded with gratitude, fellowship, and promotion. There is a service requirement for ascension onto the upper levels of the board and taking senior leadership roles in the organization and committee work is the best place to start. Please look at the following committee opportunities and let me know of your interest to serve.

Auditing Committee - Conducts an audit and/or review of the financial statement and transactions of the Society.

Best Paper Award Committee - Reviews all maxillofacial and craniofacial papers published in the Plastic and Reconstructive Surgery (PRS) during the previous calendar year and select the best clinical and best research paper for that year.

Constitution and Bylaws Committee - Receives suggestions and initiate proposals for the alteration or amendment of the Constitution and Bylaws.

Education Committee - Plans and designates activities in order to increase the knowledge and skills of ASMS Members in the areas of maxillofacial and craniofacial surgery.

Educational Grants Committee - Assists with the development, implementation and the selection of candidates for research grants, fellowships, and scholar programs.

Ethics Committee - Investigates complaints alleging violations of the Society's Bylaws and Code of Ethics or any other conduct detrimental to the best interest of the Society.

Finance Committee - Assists the Treasurer in the development and maintenance of a budget and the overall financial records of the Society.

Maxillofacial News Committee - Issues a periodic newsletter which will include newsworthy items related to maxillofacial and craniofacial surgery.

Membership Committee - This is perhaps the most important committee in the organization as it is charged with increasing, recruiting, and credentialing new membership, the lifeblood of our society.

Scientific Program Committee - Arranges the scientific program for the annual meeting.

Visiting Professor Committee - Assists with the development, implementation and the selection of visiting professor for the upcoming academic year (June – July).

Web Page Committee - Assists with the development, enhancement, review and maintenance of the ASMS website (www.maxface.org). We hope to have them initiate potential interfaces with Facebook and Twitter!

I entreat you to pick a committee and get involved! I look forward to serving you well in the coming year!

Spotlight on the Resident Scholar Program

Devra Becker, MD

The Resident Scholar awards are given annually to residents who have an interest in pursuing a career in carniofacial surgery. These awards are presented at the ASPS/PSEF and ASMS annual meeting and consists of scholarship funds to attend the annual meeting as well as the ASPS/ASMS Pre-Conference Symposium. In 2009, ASMS offered 15 of these awards. Dr. Chad Gordon, a CCF resident was included among these awardees.

Maxillofacial News: Chad, how did the grant help you?

Chad Gordon: This grant afforded me the opportunity to attend the craniomaxillofacial symposium preceeding this past year ASPS/PSEF and ASMS annual meeting. In addition, it allowed me the invaluble opportunity to obtain insightful guidance from current experts such as Drs. Wexler, Buchman and Losee.

Maxillofacial News: How did this grant influence your career path?
Chad Gordon: This award helped to solidify my passion for craniofacial surgery. After completing my plastic surgery residency at the Cleveland Clinic this past June, I entered a Craniomaxillofacial Fellowship under the guidance of Dr. Michael Yaremchuk at the Massachusetts General Hospital. This additional year of training, complete with adult facial reconstruction, will hopefully prepare me for a career in craniomaxiollofacial allotransplantation.

If you are interested in the Resident Scholar Program, it requires nomination from your current Program Director by submitting a letter describing your interest in maxillofacial surgery along with your CV.

This program is generously supported by an educational grant from Biomet Mircofixation.

***Left to right:** Dr. Chad Gordon & Dr. Steven Buchman*

2009 Resident Scholars

ASMS thanks these corporations for their generous support!

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ASPS/ASMS Pre-Conference Symposium

Robert Havlik, MD
Indiana University

The Golden Triangle: Aesthetic and Reconstructive Surgery of the Eyes, Nose, & Mid-Face is the topic of the Pre-Conference Symposium that will be held on Thursday, September 30 at the Intercontinental Hotel in Toronto. The program and faculty of this advanced one-day symposium have been specifically selected to provide the state-of-the-art information essential to contemporary plastic surgery practice in this absolutely crucial area of the face. The program will feature both a discussion of management paradigms for the clinical problems of the face, as well as provide technical pearls and insights into the difficult issues in the management of fractures, reconstruction, and aesthetic surgery in the "Golden Triangle".

Featured faculty include Dr. Paul Manson providing his experience and insight in a discussion of issues in contemporary management of orbital fractures, a discussion that will provide some new conclusions based upon a wealth of experience and may surprise many in the audience. Dr. Glenn Jelks will discuss applied orbital anatomy and management of the lower lid in blepharoplasty and Dr. Henry Kawamoto will discuss aesthetic goals in the management of naso-orbito-ethmoid fractures. Dr. Joe Losee will discuss experience with pediatric facial fractures, and how these problems differ from adult fracture management and Dr. Roberto Flores will present work on the trans-caruncular approach to medial orbital fractures. Dr. Ron Zuker will present his current approach to facial reanimation and Dr. Jesse Taylor will present exciting new clinical work on tissue engineering in the facial skeleton – a truly translational step from bench to bedside.

Dr. Joe McCarthy will lead off the afternoon program with his perspective on the fusion between aesthetic and reconstructive surgery within plastic surgery; followed by Dr. Rod Rohrich providing insight into the important role that fat compartments of the face play in facial rejuvenation. Dr. Michael Yaremchuk will then provide his insight about the use of alloplastic materials in creating mid-facial convexity. The section on nasal surgery includes Dr. Fred Menick discussing complex mid-facial reconstruction with emphasis on nasal reconstruction and Dr. Bahman Guyuron discussing aesthetic rhinoplasty with Dr. Shashidhar Kusuma presenting the current approach for assessment of functional airway assessment and endoscopic treatment of functional nasal obstruction – a talk that will certainly provide insight into new skills that are available for patients that many plastic surgeons will find beneficial.

Taken together, the program provides a comprehensive review of the current state-of-the art in a single day symposium by acknowledged masters in this important area of the face. An absolutely great way to start off a super meeting in the wonderful city of Toronto!!

The program is accredited for 8 hours of CME credit and 1 hour of Patient Safety credit.

ASMS Programs & Events

Plastic Surgery 2010
Toronto Canada
October 1-5

Thursday, September 30

(900) The Golden Triangle of the Face: Aesthetic and Reconstructive Surgery of the Eyes, Nose and Mid-Face
Time: 7AM - 5:30PM
Program Co-Chairs: Robert Havlik, MD and Pravin Patel, MD
8 AMA PRA Category 1 Credits™

Jointly Sponsored by: ASPS and ASMS
This advanced one-day symposium will provide insight into the current management of the critical structures of the golden triangle of the face, including the eyes, nose and mid-face. Management paradigms for many of the clinical concerns and disorders in this crucial region of the face continue to undergo constant evolution and revolution.

ASMS Board of Trustees Meeting
Time: 3:30 - 5:00PM

Friday, October 1

ASMS Committee Meetings
Time: 7:00AM - 1:00PM

Saturday, October 2

Scientific Paper Sessions - Craniomaxillofacial
Times: 8:00 - 9:00AM and 10:30 - 11:45AM

OFFICIAL ASMS DAY

Sunday, October 3

Panel: Facial Fractures - The New Issues
Times: 8:00 - 9:00AM
Moderator: Larry Hollier, MD
Invited Panelists: *Oleh Antonyshyn, MD; Patrick Kelley, MD; Warren Schubert, MD*

Panel: Genioplasty and Beyond - the Neck and Chin
Time: 9:30 - 10:30AM
Moderator: *Bahman Guyuron, MD*
Invited Panelists: *Joel Feldman, MD; Vincent Giampapa, MD; S. Anthony Wolfe, MD; Barry Zide, MD*

ASMS Converse Lecture: The Management of Skull Base Tumors
Time: 10:30 - 11:30AM
Lecturer: *Ian Jackson, MD*

ASMS Research Grant Awards Presentations
Time: 11:30 - 11:45AM

ASMS Luncheon and Annual Business Meeting
Time: 11:45AM - 1:15PM
Fee: $50

Audience: All registrants are invited to attend the luncheon. The Annual Business Meeting will immediately follow and is for ASMS Members only.

Panel: Facial Soft Tissue Defects What To Do Now?
Time: 1:15 - 2:15PM
Moderator: *Scott Paul Bartlett, MD*
Invited Panelists: *John Coleman, MD; Julian Pribaz, MD; Ian Jackson, MD; Frederick Menick, MD*

Panel: Rhinoplasty-Septum, Valves and Turbinates: The Functional Considerations in the Nose
Time: 2:15 - 3:15PM
Moderator: *Francis Papay, MD*
Invited Panelists: *Mark Constantian, MD; Ronald Gruber, MD; Jack Gunter, MD*

Panel: Improving Craniofacial Surgery - Lessons from Cosmetic Surgery
Time: 3:15 - 4:00PM
Moderator: *Andrew Wexler, MD*
Invited Panelists: *Sydney Coleman, MD; Mutaz Habal, MD; Michael Yaremchuk, MD*

ASMS Presidential Reception - All ASMS Members Invited!
Time: 6:30 - 9:30PM
Location: Sheraton Club Lounge
Supported by: KLS martin L.P.

ASMS Slate of Candidates

The following ASMS Slate of Candidates was proposed by the 2010 ASMS Nominating Committee, chaired by Kevin Kelly, MD, and approved by the ASMS Board of Trustees. An e-mail will be sent to Active and Senior members informing them of the ASMS slate of nominees electronic balloting process, website information and voting instructions.

President
STEVEN BUCHMAN, MD
Ann Arbor, Mich.

Academic Position/Title: Professor of Surgery & Neurosurgery, University of Michigan Medical School; Director of Craniofacial Anomalies Program, University of Michigan Medical Center; Chief, Pediatric Plastic Surgery, C.S., Mott Children's Hospital
Current ASMS Board Position: President-Elect
Past ASMS Board Position: First Vice President, Secretary, Assistant Secretary
Current Committee Work: ASMS Constitution and Bylaws Committee; ASMS Educational Grants Committee; ASMS Development Committee; ASMS Scientific Program Committee; ASMS Finance Committee; Annual Meeting Council; Research Oversight Committee (ASMS Representative); Maintenance of Certification Coordinating Council (Advisory Council Representative)
Other/Past Committee Work: ASMS Constitution and Bylaws Committee; ASMS Research Committee (Chair); ASMS Membership Committee (Chair); ASMS Nominating Committee; ASMS Educational Grants Committee (Chair); PSEF In-Service Examination Committee (Craniomaxillofacial); ASPS Bylaws Committee; ABPS Examiner; Scientific Program Committee; Government Relations Committee; Plastic Surgery Research Council (Chair); PSRC Program Committee (Chair); Research Grants Committee
Medical Degree: Medical College of Virginia; General Surgery and Plastic Surgery: Hospital of the University of Pennsylvania; Craniofacial Fellowship: UCLA
Years in Practice: 17
ABPS Certification: 1995

President-Elect
ROBERT HAVLIK, MD
Indianapolis

Academic Position/Title: Harbaugh Professor of Surgery, Indiana University School of Medicine; Vice-Chief Division of Plastic Surgery; Chief of Plastic Surgery, Riley Hospital for Children; Director Cleft and Craniofacial Program, Riley Hospital for Children
Current ASMS Board Position: First Vice President
Past ASMS Board Position: Assistant Secretary, Vice President of Administrative Duties, Historian, Parliamentarian, Member-At-Large
Current Committee Work: ASMS Scientific Program Committee (Chair); ASMS Task Force on Socioeconomic Issues/Reimbursement (Associate Chair); ASMS Education Committee; ASMS Finance Committee; Coding and Payment Policy Committee; Program Committee (Craniomaxillofacial/Head and Neck Subcommittee, Chair); Quality and Performance Measurement Committee
Other/Past Committee Work: ASMS Maxillofacial News Committee (Chair); ASMS Membership Committee (Chair); ASMS Task Force on Socioeconomic Issues; ASMS Education Committee; ASMS Task Force on Reimbursement; Coding and Payment Policy Committee; Strategic Education Council; Quality and Performance Measurement Committee; Plastic Surgery Caucus; Maintenance of Certification (MOC) Task Force; Scientific Program Committee; In-Service Examination Committee; Government Relations Committee; Health Policy Analysis Committee; ASPS/PSEF Young Plastic Surgeons Forum
Medical Degree: Yale University School of Medicine; General Surgery and Plastic Surgery: Yale University; Hand Fellowship: Harvard University; Craniofacial Fellowship: Hospital of the University of Pennsylvania/Children's Hospital of Philadelphia
Years in Practice: 16
ABPS Certification: 1995, Re-Certification 2003; ABPS CAQ Surgery of the Hand 1996, Re-Certification 2005

First Vice President
HENRY VASCONEZ, MD
Lexington, Ky.

Academic Position/Title: Chief, Professor of Surgery, Division of Plastic Surgery; Professor, Surgery and Pediatrics; Program Director, Division of Plastic Surgery Residency Program, University of Kentucky Medical Center; William Stamps Farish Endowed Chair of Plastic Surgery
Current ASMS Board Position: Treasurer
Past ASMS Board Position: Treasurer, Assistant Treasurer, Assistant Secretary
Current Committee Work: ASMS Finance Committee; ASMS Scientific Program Committee; and ASMS Auditing Committee; Finance & Investment Committee
Other/Past Committee Work: ASMS Membership Committee (Chair); ASMS Outcomes Committee (Chair); ASMS Auditing Committee (Chair); ASMS Finance Committee; ASMS Biomaterials Committee; Scientific Program Committee; ASPS Guidelines Subcommittee; Scientific Program Committee (Craniomaxillofacial); Socioeconomic Committee; Council of Regional Societies Steering Committee; International Committee; PSEF Nominating Committee; Educational Technology Committee; ASPS/PSEF Marketing Committee; Undergraduate Education Committee (Chair); Research Fund Proposals Committee; In-Service Examination Committee; International Task Force; CPT/RUC Committee; ASPS/PSEF Joint Outcomes Committee; Patient Care Parameters Committee; Council of Plastic Surgery Organizations; Finance & Investment Committee; Computer-Based Education Committee
Medical Degree: Central University Medical School; General Surgery Residency: University of Illinois; Plastic Surgery Residency: Emory University; Craniofacial Surgery Fellowship: International Craniofacial Institute, Dallas
Years in Practice: 22
ABPS Certification: 1989

Secretary
WILLIAM HOFFMAN, MD
San Francisco

Academic Position/Title: Professor and Chief, Plastic Surgery, University of California - San Francisco
Current ASMS Board Position: Secretary
Past ASMS Board Position: Secretary, Member-at-Large
Current Committee Work: ASMS Best Paper Award Committee (Chair); ASMS Finance Committee; ASMS Task Force on Socioeconomic Issues/Reimbursements (Chair); ASMS Web Page Committee; Curriculum Development Committee
Past Committee Work: ASMS Best Paper Award (Chair); ASMS Finance Committee; ASMS Educational Grants Committee; ASMS Maxillofacial News Committee; ASMS Task Force on Socioeconomic Issues; ASPS Nominating Committee; Computer Based Education Committee; ASPS/PSEF Young Plastic Surgeons Forum; Scientific Program Committee; PSEF Symposia Committee; Teleplast Committee; Resident Information Committee; Visiting Professor Committee; CPT/RUC Committee; PSEF/ASPS Committee on Maintenance of Certification; ASPS Clinical Symposia Committee; Program Committee (Cranio/Maxillofacial/Head and Neck)
Medical Degree: University of Rochester
Years in Practice: 24
ABPS Certification: 1987

Assistant Secretary
PETER J. TAUB, MD
New York

Academic Position/Title: Associate Professor, Surgery and Pediatrics, Mount Sinai Kravis Children's Hospital; Co-Director, Mount Sinai Cleft and Craniofacial Center
Current ASMS Board Position: Assistant Secretary
Current Committee Work: ASMS Education Committee; ASMS Finance Committee; ASMS Scientific Program Committee; ASMS Membership Committee (Chair); Young Plastic Surgeons Steering Committee; In-Service Examination Committee; Program Committee; Curriculum Development Committee; Program Committee (Craniomaxillofacial/Head and Neck Subcommittee)
Other/Past Committee Work: ASMS Best Paper Award Committee; ASMS Scientific Program Committee; ASMS Education Committee; Public Education Committee; In-Service Examination Committee; Program Committee; Finance & Investment Committee
Medical Degree: Albert Einstein College of Medicine, 1993
Years in Practice: 9
ABPS Certification: 2003 (ABS Certification: 2001)

Treasurer
KANT YK LIN, MD
Charlottesville, Va.

Academic Position/Title: Professor, Department of Plastic Surgery; Chief, Division of Craniofacial Surgery, University of Virginia School of Medicine
Current ASMS Board Position: Assistant Treasurer
Past ASMS Board Position: Assistant Treasurer, Assistant Secretary, Member-At-Large
Current Committee Work: ASMS Task Force on Socioeconomic Issues/ Reimbursements; ASMS Finance Committee (Chair); ASMS Development Committee; ASMS Education Committee
Past Committee Work: ASMS Task Force on Socioeconomic Issues; ASMS Research Committee (Chair); ASMS Best Paper Committee (Chair); ASMS Practice Parameters Committee; ASMS Scientific Program Committee; ASMS Nominating Committee; ASMS Fellowship Review Committee; ASMS Membership Committee; Scientific Program Committee
Medical Degree: Mount Sinai School of Medicine; Residency General Surgery and Plastic Surgery: Hospital of the University of Pennsylvania; Fellowship Pediatric Craniomaxillofacial Surgery: Hospital for Sick Children, University of Toronto
Years in Practice: 18
ABPS Certification: 1994

Assistant Treasurer
DONALD MACKAY, MD
Hershy, Pa.

Academic Position/Title: William P. Graham III, Professor of Plastic Surgery; Professor of Surgery and Pediatrics, Vice Chair Department of Surgery, Penn State Milton S. Hershey Medical Center
Current ASMS Board Position: Vice President of Administrative Duties
Past ASMS Board Position: None
Current Committee Work: ASMS Education Committee (Chair); ASMS Finance Committee; ASMS Scientific Program Committee; ASMS Task Force Socioeconomic Issues/Reimbursements; Instructional Course Committee; Program Committee; Curriculum Development Committee; MOC Coordinating Council (ABPS Advisory Council Representative, ASMS)
Past Committee Work: ASMS Education Committee; ASMS Finance Committee; ASMS Scientific Program Committee; ASMS Task Force Socioeconomic Issues/Reimbursements; MOC Coordinating Council (ABPS Advisory Council Representative, ASMS)
Medical Degree: Medical School University of Witwatersrand, South Africa; Residency: Penn State Milton S. Hershey Medical Center
Years in Practice: 23
ABPS Certification: 1997, Re-certification 2006

VP of Administrative Duties
ARUN GOSAIN, MD
Cleveland

Academic Position/Title: DeWayne Richey II Professor and Vice Chair, Department of Plastic Surgery, Case Western Reserve University, Cleveland
Current ASMS Board Position: Historian
Past ASMS Board Position: Historian, Treasurer
Current Committee Work: ASMS Newsletter Committee (Chair), ASMS Auditing Committee (Chair), ASMS Education Committee, ASMS Finance Committee, ASMS Scientific Program Committee, ASMS Board of Trustees, ASMS Educational Grants Committee
Other/Past Committee Work: ASMS Education Committee; ASMS Educational Grants Committee (Co-Chair); ASMS Finance Committee; PSEF Volunteers in Plastic Surgery Steering Committee; ASPS/PSEF Bylaws Committee; Visiting Professor Committee; International Scholar Committee; Health Policy Committee; PSEF Nominating Committee; PRS Editorial Board; Senior Residents Conference Committee; E-Learning Committee; Scientific Program Committee; PSEF In-Service Examination Committee; ASPS/PSEF Maintenance of Certification (MOC) Committee; Computer Based Education Committee; ASPS/PSEF Joint Outcomes Committee; Research Grants Committee; ASPS/PSEF Marketing Committee; PSEF Volunteers in Plastic Surgery Steering Committee; ASPS/PSEF Bylaws Committee; Visiting Professor Committee; International Scholar Committee
Medical Degree: UCLA School of Medicine
Years in Practice: 18
ABPS Certification: 1994

VP of Communications
JOSEPH LOSEE, MD
Pittsburgh

Academic Position/Title: Associate Professor of Surgery and Pediatrics, University of Pittsburgh School of Medicine; Chief, Division of Pediatric Plastic Surgery, Children's Hospital of Pittsburgh
Current ASMS Board Position: VP of Communications
Past ASMS Board Position: VP of Communications, Member-At-Large
Current Committee Work: ASMS Scientific Program Committee; ASMS Visiting Professor Committee; ASMS Education Committee; ASMS Finance Committee; ASPS/PSEF Board of Directors (AACPS Representative); PRS Editorial Board (Associate Editor); Research Oversight Committee (AACPS Representative); Curriculum Development Committee; Group Practice Task Force
Past Committee Work: ASMS Visiting Professor Committee (Chair); ASMS Task Force on Socioeconomic Issues; ASMS Education Committee; ASMS Scientific Program Committee; Strategic Education Council; In-Service Examination Committee; PSEF Nominating Committee; Program Committee; Publications Committee; CME Committee; ASPS/PSEF Young Plastic Surgeons Forum; Undergraduate Education Committee; Resident Information Committee; International Scholar Committee
Medical Degree: University of Rochester; General Surgery Residency: Strong Memorial Hospital, University of Rochester; Plastic Surgery Residency: Strong Memorial Hospital, University of Rochester; Craniofacial Surgery Fellowship: Children's Hospital of Philadelphia, University of Pennsylvania
Years in Practice: 10
ABPS Certification: 2001

VP of Education

WARREN SCHUBERT, MD
St. Paul, Minn.

Academic Position/Title: Professor, Department of Surgery, Professor, Department of Orthopaedics, University of Minnesota; Chair, Department of Plastics & Hand Surgery, Regions Hospital
Current ASMS Board Position: Vice President of Education
Past ASMS Board Positions: Vice President of Education, Assistant Treasurer, Member-At-Large
Current Committee Work: ASMS Education Committee; ASMS Development Committee; ASMS Scientific Program Committee; ASMS Ethics Committee; ASMS Finance Committee
Past Committee Work: ASMS Constitution and Bylaws Committee; ASMS Education Committee (Chair), Ethics Committee (Chair); ASMS Finance Committee; ASMS Scientific Program Committee; CME Committee; Scientific Program Committee; Program Committee; Plastic Surgery Work Force Task Force; Academics Task Force; PSEF Volunteers in Plastic Surgery Forum
Medical Degree: University of North Dakota; Family Practice Residency: University of Texas, San Antonio; General Surgery Residency: McGill University; Plastic Surgery: Case Western Reserve University; Maxillofacial Trauma Fellowship: Atlanta
Years in Practice: 19
ABPS Certification: 1993

VP of Socioeconomic Issues

PRAVIN PATEL, MD
Chicago

Academic Position/Title: Professor of Surgery, University of Illinois; Chief of Craniofacial Surgery, University of Illinois; Chief of Plastic Surgery, Shriners Hospitals for Children; Pediatric Plastic & Craniofacial Surgery, Children's Memorial Hospital; Adjunct Professor Neurosurgery/Plastic Surgery Northwestern University; Adjunct Professor Biomedical Engineering, Marquette University
Current ASMS Board Position: Vice President of Socioeconomic Issues
Past ASMS Board Positions: Vice President VP of Socioeconomic Issues, Member-at-Large
Current Committee Work: ASMS Education Committee; ASMS Web Page Committee; ASMS Educational Grants Committee; Curriculum Development Committee
Past Committee Work: ASMS Education Committee; ASMS Maxillofacial News Committee; Curriculum Development Committee
Medical Degree: Hahnemann University School of Medicine; General Surgery: Mayo Clinic; Plastic Surgery Fellowship: University of Chicago; Plastic & Reconstructive Surgery Residency: Northwestern University Medical School; Craniofacial **Fellowship:** UCLA
Years in Practice: 16
ABPS Certification: 1999

Historian

DELORA MOUNT, MD
Madison, Wis.

Academic Position/Title: Associate Professor, Division of Plastic and Reconstructive Surgery Chief, Pediatric Plastic Surgery at American Family Children's Hospital, Director of Craniofacial Anomalies Clinic
Current ASMS Board Position: Parliamentarian
Past ASMS Board Position: Parliamentarian
Current Committee Work: ASMS Constitution & Bylaws Committee; ASMS Education Committee; ASMS Membership Committee; ASMS Visiting Professor Committee (Chair); PSEF Volunteers in Plastic Surgery Steering Committee; Program Committee (Research/Technology Subcommittee); Curriculum Development Committee
Other/Past Committee Work: ASMS Constitution & Bylaws Committee; ASMS Education Committee; ASMS Membership Committee; ASMS Visiting Professor Committee; PSEF Volunteers in Plastic Surgery Steering Committee; Program Committee; International Services Committee; In-Service Examination Committee; Young Plastic Surgeons Steering Committee; Curriculum Development Committee
Medical Degree: University of Illinois; General Surgery Residency: Indiana University Medical Center; Plastic and Reconstructive Surgery Residency: University of California; Craniofacial & Pediatric Plastic Surgery Fellowship: Washington University, St. Louis Children's Hospitals
Years in Practice: 9
ABPS Certification: 2002

Parliamentarian

JACK YU, MD
Augusta, Ga.

Academic Position/Title: Milford B. Hatcher Professor; Chief, Section of Plastic & Reconstructive Surgery, Medical College of Georgia; Chief, Pediatric Plastic & Reconstructive Surgery, Children's Medical Center
Current ASMS Board Position: None
Past ASMS Board Position: Member-At-Large
Current Committee Work: ASMS Scientific Program Committee; ASMS Education Committee; ASMS Educational Grants Committee (Chair); Curriculum Development Committee
Past Committee Work: ASMS Membership Committee; ASMS Nominating Committee; ASMS Scientific Program Committee; ASMS Fellowship Grant Committee; ASMS Educational Grants Committee; ASMS Biomaterials Committee; ASMS Education Committee (Chair); PSRC Development Committee; PSEF/ASMS International Scholar Committee
Medical Degree: University of Pennsylvania
Years in Practice: 16
ABPS Certification: 1996, Re-Certification 2004

** Note: The Parliamentarian position is appointed by the ASMS President each year to serve on the Board of Trustees and does not require a vote by the membership..*

Historian's Corner

ACGME and Me: An Examination of the History of Craniofacial Fellowships

S. Anthony Wolfe, MD
Chief, Division of Plastic Surgery
Miami Children's Hospital

I was most fortunate to be able to spend a year with Paul Tessier in Paris after completing my Plastic Surgery residency with Ralph Millard in 1974. "Training" with Tessier meant going to a small obstetric hospital on the outskirts of Paris, Clinique Bélvèdere; and for many, trying to see what this authentic surgical genius was doing from the other side of a sheet stretched between two IV poles. With his enormous surgical output of 10 to 15 cases a day, 6 days a week, Tessier did not take much time explaining to the assembled masses what he was doing. After the dozen or so visitors had left for dinner, I stayed on as Tessier worked into the late hours. I think at this point he enjoyed having some company and was happy to talk to me about what he felt were important points of the specialty that he had single-handedly created, craniofacial surgery, as well as a great many other things.

There was no formal position with him under the French educational hierarchy, since at this point he had resigned as head of the Department at Hospital Foch, and only went there one afternoon a week to operate. A number of the many Americans who visited Tessier over the years returned to the U.S. and claimed to have been "trained by Tessier", even though they had only been there for a week or two. As a result of this, Dr. Tessier had provided another "Tessier Classification": people who had been with him a year or more=assistant; 6 months to a year=fellow; two to six months= visitor; less than two months=tourist. No one received any sort of certificate from him—only knowledge. I went back to him several times a year over the next 30 years for the very best of "continuing medical education", which involved advice on complex cases, and eventually being given the great privilege to go through all of his patient records. If someone had asked him to provide "the educational goals and objectives of his fellowship", I can only imagine his response.

I returned to Miami in 1975 and went into practice with Ralph Millard, who was a great soft tissue surgeon, but who had no interest in working with bone. I was brought in as the "hard tissue" man, and with what I had learned from Dr. Tessier and others that he recommended we visit (specifically, Jacques Dautrey, who performed superb sagittal splits with tremendous finesse, and Hugo Obwegeser, the great pioneer of both the sagittal split and maxillary orthognathic surgery), I was able to put to use my new, yet still spotty knowledge of craniofacial and maxillofacial surgery on the back log of patients needing this kind of work. From 1975 to 1980, I did a good bit of intracranial and orthognathic surgery, let us say learning as I went along, and benefiting from encouragement and advice from Dr. Tessier.

Henry Kawamoto and I had just missed each other in Paris; we met for the first time in Chicago in 1975 at one of the early craniofacial meetings, and became good friends. We gave a course for 10 to 15 years on orthognathic surgery at ASPRS, famous for our spirited disagreements on subjects such as whether to do sagittal splits or intraoral verticals for mandibular prognathism (I won that argument, recommending the former, and he certainly prevailed in many other instances).
Both Henry and I joined ASMS in the mid-1970's. ASMS seemed to us at the time to be enveloped in dust and cobwebs, and it did not seem that the members, most of whom had dual degrees, were doing much maxillofacial surgery. I can recall one ASMS President (a dual degree man), who called me (medical degree only) and said that he was going on a lecture tour abroad, and had been asked to talk about orthognathic surgery; did I possibly have any cases of sagittal splits that I could "loan" him (since he obviously had never done the procedure)? Henry and I both went on to be ASMS Presidents, he first, and I in 1991-92.We both felt that ASMS should be the organization dealing with facial trauma, orthognathic, and yes, some areas of aesthetic interest such as "facial contouring". Major intracranial surgery would be dealt with in others arenas, such as The International Society of Craniofacial Surgery, of which Henry and I were both Founding Members. Having the primary focus of ASMS be primarily aesthetic surgery we felt would be wrong.

In the later 1970's and early 1980's, I went to the University of Florida to do craniofacial cases on a regular basis, and had Hollis Caffee, their microsurgeon, come to Miami to help me with cases who needed free flaps (most famously, we did several dozen omental free flaps for conditions such as Romber's and hemifacial microsomia, and I can report that they all looked great initially, and all eventually sagged disgracefully). One of the residents at the University of Florida who scrubbed with me on some of the craniofacial cases was quite interested in what I was doing, and asked if he could spend some time with me after he finished in Gainesville. This was 1981: I told him that I would be honored, but that I had no way of providing any financial support. He took several moonlighting jobs to sustain himself, and was there for the craniofacial cases. Following him, I can count 64 photos on my "wall of fame" of young plastic surgeons who spent either 6 months or a year with me. There was one who did not turn out well, and he is not on the wall.

After the first fellow, I was able to find financial support from a number of sources: The Mailman Foundation, thanks to the generosity of Joseph Mailman, the Walter Lorenz Company, and the Leibinger Company. We also found that if the Fellow had a Florida Medical License, we could bill for assistants' fees. Then, through the generosity of Ambassador David Walters, Miami Children's Hospital provided a salary line for a craniofacial fellow. There was no "accreditation" for the fellowship, but the Fellow did receive a little certificate signed by myself and the Dean of the University of Miami School of Medicine.

During my ASMS Presidency (1991-92), one of the items on our Board agenda was whether to seek Accreditation from the Accreditation Council for Graduate Medical Education (ACGME) and the Plastic Surgery Residency Review Committee (RRC) for Craniofacial Fellowships. The RRC and the American Board of Plastic Surgery (ABPS) had been having problems with the "CAQ" (Certificate of Additional Qualification) in Hand Surgery, and were reluctant to go ahead with accrediting what they felt would be a small number of Craniofacial Fellowships. The ASMS Board seemed to be interested in seeking accreditation largely because it was felt that if we did not "capture" the process, another specialty might do so. The issue was pursued for years, including at COPSO (Council of Plastic Surgery Organizations), and the response of the RRC was that it just couldn't be done. The logjam was finally broken when Ed Luce brought to COPSO several orthopedic surgeons who said that there had been no problem in obtaining accreditation for their subspecialty fellowships from ACGME.

So, almost a decade after my Presidency, the Plastic Surgery RRC formulated Program Requirements for Craniofacial Fellowships which would allow for ACGME accreditation. The initial requirements were that there be at least 24 fellowships, and that they be open to men and women from other specialties than Plastic Surgery. Since I had been involved in the initial discussions concerning accreditation, I felt that I should go through the process that I had advocated. We sent in our application, which involved all of the paperwork required for a Plastic Surgery residency. We had an initial site visit in 2001, with the Site Visitor being an Ob/Gyn man from a Southern state. He had several worthwhile recommendations for us, and we received accreditation, which allowed the hospital to collect Federal funds to support the fellow. One of the Program Requirements was that the Chairman of the "affiliated" Plastic Surgery residency sign the Program Information Form (PIF). The Plastic Surgery Program Chairman that I had been closest to declared that he would sign the form only if there were a substantial payment, which I was not in a position to provide. I asked Doris Stall, PhD., who was the Plastic Surgery RRC Secretary if it made any difference which Plastic Surgery residency was the affiliate, and she said no. So, the initial signature on my PIF was from my old friend Hollis Caffee, who by this time was Chairman at the University of Florida (without any exchange of funds). Later we did work out an arrangement whereby some funds were paid by Miami Children's Hospital to the other Residency, and the PIF was signed by its Chief.

We then had a second site visit in 2005, this time by a pediatrician from another Southern state. In retrospect, I should have taken this more seriously than I did. The site visitor had a number of questions that I could not answer (where were my written evaluations of my faculty? Something that I was unaware was necessary), and there were a number of other paperwork and documentation deficiencies (Prometheus probably felt the same way as his liver was pecked away by an eagle). In the report that came from the RRC, I received 7 citations. Two were simply incorrect (I was cited for having two fellows, when I had only one; I was cited for having a fellow who had not come from an ACGME accredited program, when in fact he had). The other 5 citations were for not having a clear enough expostulation of the "educational goals and objectives of the Fellowship" (I had listed something along the lines of

passing on to the Fellow what I had learned from Paul Tessier), the letter of Support of the Director of Internal Operations (DIO or Chief Medical Officer) was inadequate, and the like. I was given the opportunity to respond to all of these citations, but the final letter from the RRC informed me that our Fellowship had been disaccredited. Interestingly, at the end of the letter the suggestion was made that we go through the accreditation process all over again.

Now, this came as a substantial blow to my ego. This was a flunk, something that I had never had in college or medical school. My initial response was, why bother with a lot of hassle for something that the Fellows themselves did not care about. The only entity that seemed to advocate accreditation was my institution, Miami Children's Hospital. During my tenure as President of The International Society of Craniofacial Surgeons, I considered suggesting that that Institution take over the accreditation process on a worldwide basis, bypassing our RRC, but didn't.

After some thought, I swallowed my pride, and we did go through the accreditation process again, taking it much more seriously. We had every item covered by reams of paper work, and had our application gone over by a previous RRC member. This time our site visitor was not a physician, but a professional pedagogue. She was gentle with us, and we did in fact receive "re-accreditation", for which we received kudos from our Administration. Our Fellows, however, were not altogether happy, since this seemed to mean that they could no longer bill for assistants' fees.

So, what are my feelings on the Accreditation Process at this moment?
In some areas, it remains petty: we are obliged to speak of the fellow as the "craniofacial resident", which he or she is not. A resident is in a residency program, and a fellow in a fellowship. Obliging the Program Director to articulate a progressive assumption of responsibility by the Fellow does not take into account the differences in surgical abilities of different surgeons. I have had some Fellows who I have been happy to turn an entire operation over to, and others who I am not so comfortable with even when I am helping them. It is unfair to the patient if the initial dissection takes three or four times as long if done independently by the Fellow. I am not a particularly good assistant, since if things are not going exactly as I would like, the instruments have a way of ending up in my hands. Spelling out the criteria for hiring and firing a fellow is not a bad thing, and gives legal cover if the latter ever becomes necessary (which it should not if the initial selection had been done properly).

I suppose my greatest criticism would be that the Accreditation Process does not look at the quality of the work being done. A program where only Le Fort 3 osteotomies are done by distraction could rank as highly as one where a significant number of intracranial advancements were done. A program where 100% of the cases of cranial base procedures had CSF leaks would rank as well as one where the incidence was 2%. A program, which Paul Tessier would only shake his head about, could rank as highly as one that he would be proud of. Since the site visitors are able only to look at the process, the adherence to the paperwork demands, there is no evaluation of patient outcome. The way to remedy this would be to include "benchmarking" of outcomes in the overall Accreditation Process, but this would require peer review by a surgeon capable of evaluating this sort of data.

Another shortfall is that there are a number of excellent fellowships (Ortiz Monasterio/Molina in Mexico City, Marchac/Arnaud in Paris) that don't exist as far as the ACGME is concerned. A year with Dr. Tessier, in fact, would not be possible under ACGME purview. And conversely, excellent candidates from abroad do not qualify for American Craniofacial Fellowships under present criteria since they do not come from ACGME accredited training programs.

Finally, the requirement of having the signature of the "affiliated" plastic surgery residency Chairman should be dropped. The educational program of a free standing Children's Hospital should be judged on its own merits, and not be dependent on the nearest University Program, where craniofacial surgery may not even be done. The ACGME is presuming here that there is a congenial relationship between the two Program Directors, which unfortunately may not always be the case.

In the final analysis, however, I do think, however, that all Craniofacial Fellowships Directors should be involved in the Accreditation Process, and that the RRC and ACGME should be ready to listen to the comments and suggestions that they and their Fellows have about the overall process. The fact that only 4 or 5 of the several dozen existing craniofacial fellowships have opted to go through the accreditation process should indicate that the process should be made less Draconian and more user friendly.

The ACGME is a non-governmental agency, with its membership nominated by the alphabet soup of ABMS, AHA, AMA, AAMC and CMSS (you can find the meaning of these acronyms on their website). It can pretty much do as it sees fit, since it is not beholden to anyone, but it seems to be most concerned about limiting government intervention in the educational process to the point that it often comes up with regulations that are more inane and onerous than the government itself might produce. A case in point is the "80 -hour work week", where a resident can be home in bed and field calls from the hospital all through the night and get little sleep, but not have this count towards the 80 hours, but have 12 hours of uninterrupted slumber in an on-call room in the hospital and have this count. I am afraid that most surgical educators are reluctant to point out the imbecility of this kind of thing, since they live in fear of retribution from an agency that literally has life and death control over their programs.

Craniofacial Surgery is a team effort, and our Fellowship would not be possible without the input of Joe Garri, Chad Perlyn and Deirdre Marshall, Plastic Surgeons, Lennie Rothenberg and Phil Kainer, orthodontists, John Ragheb, Glenn Morrison and Sanjiy Bhatia, neurosurgeons, Mislen Bauer, geneticist, who heads our Craniofacial Clinic, the intensivists who staff our Pediatric ICU, our pediatric anesthetists, and many others. But most of all, gratitude goes to Paul Tessier, for setting a gold standard that we can aspire to, but never attain. Semper Investigans, Nunquam Perficiens, as Dr. Millard had on his "coat of arms."

FIGURE 1. *Tessier devotees at one of the early Craniofacial Surgery meetings, Chicago, 1975. At this point, Craniofacial Surgery was 8 years old, if we use Dr. Tessier's 1967 presentation in Rome as the beginning.*

From left: Hans Peter Freihofer, Henry Kawamoto, Elizabeth Hecht, Doug Ousterhout, Paul Tessier, Martine Peyronie, Walter Pepersack, and Tony Wolfe

FIGURE 2. *Miami Children's Hospital Craniofacial Fellows, some on the wall and the 2009-2010Fellows Renee Burke and Rob Morin, soon to be on the wall. Craniofacial Surgery is by now 43 years old.*

These are the author's personal views, not those of ASMS.

Book Review
Rhinoplasty: Craft and Magic

Mark Constantian, MD

Review by: Jeffrey R. Marcus, MD FAA FACS

Rhinoplasty is an art within plastic surgery that is practiced by some and avoided by many. The masters of this discipline are known to most of us by name. Expert rhinoplasty surgeons are a relatively small group. To be a master in a specialized practice implies that one has delivered, over the course of a career, contributions which will be remembered by those who follow. Dr. Jack Sheen, universally acclaimed for his mastery in this field, made contributions that influence all who have followed. His legacy is seen not only in the results he produced, but in the contributions that he made in his teaching and his writings. Dr. Sheen and his disciple Dr. Constantian are scholars of rhinoplasty. Dr. Constantian's two-volume text summarizes his own teachings over his 30 years of study and contemplation. It is one of few single-author texts among recent plastic surgery publications, and it solidifies his standing as one of our master rhinoplasty surgeons.

Rhinoplasty: Craft and Magic is separated into five parts among two volumes. The lessons taught throughout the text are supported by numerous case examples. Relative to some rhinoplasty texts, diagrams are used more sparingly in favor of the overwhelming number of actual case demonstrations. The two volumes are different, and they may be useful in different ways. Volume One does two things; first, it provides understanding of the anatomy and physiology in general and in a wide array of variations. Second, it provides the conceptual framework to build a generalized approach to nasal concerns. Rhinoplasty is a test of the mind more than a challenge for the hands. Dr. Constantian uses Volume One to teach the reader how to think about this nose. He delivers some straightforward philosophies that are useful at all levels of expertise as well as some very challenging or abstract points that require careful consideration by even the more experienced. There are three sections that particularly standout to me, beginning with the discussions of functional anatomy/physiology and subsequently the four critical anatomic variants. These sections allow Dr. Constantian to elaborate upon some of his best prior writings in detail. The third is the discussion of his approach to the patient and communication that allows the patient to understand his/her concerns and the way they can be treated.

Volume Two is a practical reference guide for primary and secondary rhinoplasty. With the conceptual work completed, Dr. Constantian uses numerous actual cases to illustrate the common (and uncommon) findings in practice. It is likely that the reader would find a case among those presented in Volume Two which would bear similarity to nearly any case for which he/she is preparing. While more surgeons perform open rhinoplasty than endonasal rhinoplasty, the analysis and critical points of consideration can be used to guide successful treatment regardless of the approach. Dr. Constantian's philosophies and his methodical approach to every patient can help early or experienced surgeons avoid aesthetic or functional problems.

Dr. Constantian has shown throughout his career that rhinoplasty surgeons must understand the details and interaction of form, function, and perception. This is the theme throughout **Rhinoplasty: Craft and Magic**. It is the hope of many of us, including Dr. Constantian, that more plastic surgeons will spend the needed time to study and will perform rhinoplasty. Rhinoplasty requires more thought than other operations, but it is actually not "magic". Dr. Constantian's text should serve to remove some of the mystery.

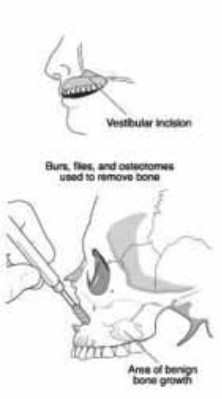
Code of the Month

Gregory Pearson, MD

21029

Removal by contouring of benign tumor of facial bone (e.g., fibrous dysplasia)

The physician removes a benign tumor from a facial bone by contouring the excess bone down to the appropriate structure. A transoral incision is made in the maxillary buccal vestibule. The physician reflects the overlying mucosa, exposing the excessive bone. Rotary burs, files, and osteotomes are used to remove this bone. The transoral incision is closed in a single layer.



Guidelines: This code is frequently used for patients with unresectable fibrous dysplasia who would like facial contouring. This code should not be used if extensive resection such as a subtotal maxillectomy is going to be performed.

What's included: Exposure of the bony overgrowth, removal of the overgrowth, and simple closure. Straight forward dissection around the mental or infraorbital nerve(s).

What's not included: Any bone grafting done (use codes 21210 for graft to malar, 21215 for graft to mandible).

Case of the Month

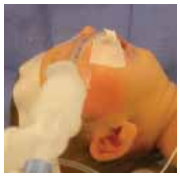
Gregory D. Pearson, MD, FACS

This is a case of a 3-week old female presenting to tertiary care pediatric neonatal intensive care unit. She was born without complication. She was unable to be weaned from oxygen and was transferred from an outside hospital for airway concerns.

Pathologic anatomy:

On clinical exam, the child has the classic appearance of Pierre-Robin sequence. She has micrognathia, cleft palate, and glossoptopsis. She required decubitus or prone positioning in order to maintain her saturations. She also required constant nasal oxygen to maintain her saturations. Upon examination, she had a U-shaped cleft of the palate. The distance between her maxilla and mandibular arches was greater than 1 cm. The remainder of her examination was grossly normal.

Operative Photo showing micrognathia



Diagnosis: Pierre-Robin sequence with associated apnea

Workup:
This child was evaluated via a multidisciplinary team consisting of an otolaryngologist, geneticist, sleep medicine doctor, and plastic surgeon. Initially the child had a sleep study demonstrating significant obstructive apnea with an apnea hyponea index of 17 (normal 1) with the patient in the decubitus position. During the study, the sleep medicine team was unable to wean her off oxygen; when attempts at weaning were made, she would automatically desaturate into the 70s and 80s. The sleep study demonstrated no central apneas suggesting that this is an anatomic cause of her apnea. The geneticist did not believe that the child had any genetic cause for the breathing abnormality such as a neuromuscular congenital abnormality. Otolaryngology performed a nasopharyngoscopy demonstrating glossoptosis without any significant signs of reflux. No supraglottic masses were identified and the vocal cords appeared normal. No laryngomalacia was appreciated. The patient had a CAT scan demonstrating severe micrognathia with class II skeletal patterns measuring 14 mm in difference. (Figure 1) The study demonstrated condyles within the temporomandibular fossa. A cine-airflow study demonstrated collapse of the tongue base against the hypopharynx with active breathing. (Figure 2)

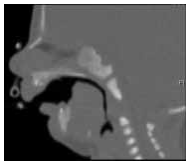


FIGURE 1. *Class II Occlusion*

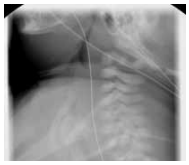


FIGURE 2. *Tongue base collapse*

Treatment options:

This patient had severe obstructive apnea secondary to Pierre-Robin sequence. Treatment options for this condition consist of prone positioning, tongue lip adhesion, tracheostomy, or mandibular distraction. The child was failing prone positioning as the primary service was unable to wean the child off oxygen. For this reason, surgical intervention was entertained. The risks and benefits of tongue lip adhesion, tracheostomy, and mandibular distraction were discussed with the parents. The parents opted for the child to undergo mandibular distraction.

Surgical approach:

The patient was taken the operating room and bilateral Risdon incisions were performed. Next bilateral vertical osteotomies were performed on the mandible with placement of mandibular distractors. The activation arms were brought out in the submental area. The patient returned to the intensive care unit intubated.

Hospital course:

Mandibular distraction was begun on postoperative day 4 with 1 mm of distraction per day. The child was taken back to the operating room for extubation on postoperative day 10. The child was able to be quickly weaned off oxygen during the next 24 hours while distraction continued during the remainder of the hospital course. A second sleep study was obtained demonstrating a significant improvement in the apnea hyponea index (0.3) while the patient was in the supine position without supplemental oxygen. Figure 3 demonstrates a radiograph of the distraction process. The parents were instructed in distraction process and the patient was discharged to home on postoperative day 19.

Considerations:

Children presenting with apnea secondary to tongue base disorders such as Pierre-Robin sequence must have a thorough workup to rule out any other causes of their apnea. For example, a child with significant central apnea secondary to a neurologic condition might not benefit from mandibular distraction or tongue lip adhesion secondary to an inability to protect the airway. Furthermore, children with significant tracheomalacia or laryngomalacia might require tracheostomy secondary to lower airway anatomical issues. Once it is deemed that the apnea is caused by an oral pharynx issue, tongue lip adhesion or mandibular distraction can be entertained. Proponents of mandibular distraction believe that it solves the underlying anatomic pathology issue, micrognathia. By surgically moving the mandible forward, the base of the tongue is brought forward, glossoptosis is relieved, and the airway improves.

Mandibular distraction was initially performed on children with hemifacial microsomia in order to level the occlusal relationships. Distraction was then applied for children with tracheostomies who were unable to be decannulated. Recently, distraction has been utilized in the neonate period to avoid tracheostomy as presented in this case. Post-operative photos are not available at this time.

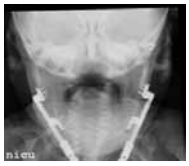


FIGURE 3. *Radiograph of distraction in progress*

Artists in Facial Restoration: Innovators in the Science of Maxillofacial Surgery

The Endoscopic Assisted Mandibular Bilateral Sagittal Split Osteotomy

"I hear and I forget. I see and I remember. I do and I understand" Confucius

Joseph Muhammad, MD DDS
International Member & Newsletter Committee Member

Introduction

Innovations in maxillofacial surgery are a series of reports for Maxillofacial News that will focus on new developments in our specialty that could impact on the care we offer our patients in a very positive way. Minimally invasive surgery brings with it may technical challenges especially when confined to the facial skeleton. One innovative procedure that has received a lot of attention from colleagues both in North America and Europe has been the endoscopic assisted mandibular sagittal split osteotomy pioneered by Professor Maurice Mommaerts.

Professor Mommaerts is an ASMS international member and is currently the President of the European Association of Craniomaxillofacial Surgery (EACMFS). The deep bonds that connect the two societies continue to be strengthened and nurtured with the passage of time. The selfless contribution of dedicated ASMS fellows to the success of the biennial EACMFS congress as occurred in Bologna 2008 and reported in Maxillofacial News October 2008 issue has not gone unnoticed and is much valued.

The transatlantic cooperation that exists between America and Europe has meant that there is a core of maxillofacial surgeons with the unique privilege of being trained on both sides of the Atlantic by some of the most distinguished surgeons of our times. Dr. S. Anthony Wolfe and Dr. Henry Kawamoto are members of this group of open minded surgeons for whom no sacrifice was too much and no distance too far in seeking out the best training and experience that maxillofacial surgery could offer. Professor Mommaerts belongs to this rare group of surgeons. He received a transatlantic education from two of the leading figures and pioneers of the maxillofacial surgery, Professor Hugo Obwegeser and Professor Ralph Millard.

The endoscopically assisted mandibular sagittal split osteotomy. The operation uses a smaller incision than the standard mandibular sagittal split osteotomy. The anterior part of the incision begins over the external oblique ridge and extends posteriorly in a lingual direction. Buccal and lingual subperiosteal tunnels are raised. The buccal subperiosteal and lingual tunnels are represented in Figure 1 as a green tube and blue tube respectively.

A specially designed retractor is used to maintain the lingual flap and a fibreoptic endoscope with high magnification checks the position of the lingula and the inferior alveolar neurovascular bundle. Indeed specially designed instruments have been critical in the successful evolution of the procedure see Figure 2.

Minimum dissection is done along the anterior border of the ascending ramus of the mandible. The Lingual cut reaches as far back as the posterior border of the ramus. The entirety of the cut including both the depth and length can be inspected with the endoscope (Figure 3).

The osteotomy at the upper border of the mandible (marked with a red line) is short in length which, means that the start of the anterior osteotomy is much more proximal than the cut for a conventional mandibular sagittal split osteotomy. The endoscope is again put to good effect. It is used to check that the anterior osteotomy cut at the lower border of the mandible is complete. Why speculate or struggle to establish if an important part of surgery has been completed, if one can get an answer immediately using the endoscope? Incomplete cut at the lower border can often lead to a 'bad split'.

Like most experienced and respected maxillofacial surgeons, Professor Mommaerts leaves nothing to chance. Once the split is complete and the proximal segment is kept in place with a Pepersack periosteal elevator. Prevention of lateral distraction of the condyle is the issue of chief concern at this stage of the operation. So a finger is placed on the condyle to detect any possible lateral displacement as the two cortices are approximated. Sometimes, despite removal of interferences from the inner surface of the cortical plates, the cortices can still remain apart at the upper border. This scenario is much better than them forcing the cortices together, which could result in the condyles being distracted laterally and cause the patient a lot of pain. After the first bicortical position screws are bilaterally in place, the intermaxillary fixation (IMF) is released and each condyle is palpated and lateral movements done with the mandible to ensure that the disc is not trapped.

The use of the transbuccal route to place bicortical position screws to secure the distal segment in its new position after completion of the mandibular split can lead to unnecessary swelling and also scars. An intra oral approach using bicortical screws is therefore used to achieve fixation of the proximal and distal segments. It was employed taking into account that bicortical screws positioned at an angle of 70 degrees to the cortex have sufficient purchase to maintain the osteotomized segments in their new position. Although Professor Mommaerts regards intraoral placement of the bicortical screws as a difficult part of the operation it was done effortlessly in my presence.

A further opportunity to minimize swelling and also avoid using a drain has been employed by Professor Mommaerts. Rather than place bilateral drains at the osteotomy sites, fibrin glue was squeezed into the buccal dead space to minimize haematoma formation and reduce infection.

Have there been any problems encountered with the procedure? Professor Mommaerts is brutally honest and frank in his appraisal in the technique, citing in his recent paper (Journal of Cranio-Maxillo-Facial Surgery 2010: 38, 108-112) the difficulties he experienced with achieving a good split with the early cases.

Discussion

Endoscopic assisted mandibular orthognathic surgery was reported by Kaban and Trollis in 2004 for mandibular setback procedures using an external approach. They used a 14mm Risdon like incision to carry out vertical ramus osteotomies of the mandible.

The procedure described by Professor Mommaerts is used for mandibular lengthening and avoids the need for a scar as it is done completely intraorally. It utilizes the benefits of the 30 degree angled endoscope which provides a good surgical view of the operative field and minimizes the need for periosteal stripping, thus allowing for a tunnel approach to be used. The endoscope brings with it other advantages including improved illumination and magnification, and instant feedback at each stage of surgery. Less periosteal stripping should translate into less post operative oedema and discomfort.

Summary

An understanding of the impact on soft tissue facial drape and aesthetic facial contours of moving different parts of the facial skeleton is essential to maxillofacial surgery. Often patients require a combination of hard and soft tissue surgery to produce a functionally and aesthetically pleasing result. Equally important for the continued success of the specialty is the need for the maxillofacial surgeon to be innovative. One of the main drivers for improvement is the demand from patients that surgery should have minimum discomfort and swelling together with an absence of scars and a short period of convalescence.

The application of new and existing technologies and the use of biomaterials have all been used by the Professor Maurice Mommaerts and his Bruges team to meet the challenges of this demanding form of surgery. Furthermore they have built their surgery on the foundation of innovations made by current and previous generations of outstanding surgeons. Advancements in the art and science of facial restoration demonstrate how science, technology and the innate inquisitive mind of the artist surgeon can be galvanized to add value to the treatment we offer to our patients.

However, it is important to realize that the endoscopically assisted mandibular sagittal split osteotomy is still an evolving technique. It is therefore a credit to Professor Mommaerts that the procedure is now being prepared for the rigueurs of robust scientific review as a prospective randomized split face study beckons. Trust, responsibility and integrity are also part of a maxillofacial surgeons make up. The public expect it from us and we in turn owe it to them. Further information about the technique can be obtained from Professor Mommaerts maurice.mommaerts@azbrugge.

Details about the forthcoming EACMFS September 2010 congress in Bruges, Belgium can be found by visiting the website www.eacmfs2010.org.

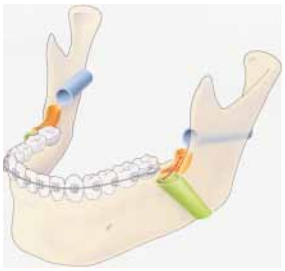


FIGURE 1. *Blue and green tubes represent the lingual and buccal subperiosteal tunnels respectively The red line indicates the incision. Reproduced with permission from Dr Mommaerts and Elsevier*

FIGURE 2. *Special instruments are required for the procedure: (A) a narrowed wedge osteotome, (B and C) modified two-pronged raspatories (Pepersack) left and right, (D) a lingual orthognathic retractor, (E) a buccal orthognathic retractor, (F) and a Freer/retractor with swan neck design (right hand side). Reproduced with permission from Dr Mommaerts and Elsevier*

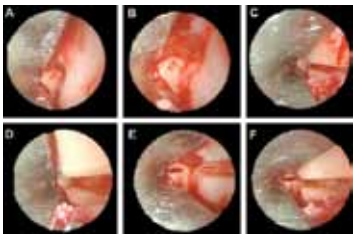


FIGURE 3. *(A-F) Endoscopic view on the lingual aspect of the mandible with increasing depth of the lingual cortocotomy. Reproduced with permission from Dr Mommaerts and Elsevier*

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InterContinental Toronto – Toronto, ON CANADA
Co-chairs: *Robert Havlik, MD & Pravin Patel, MD*
Supported by an educational grant from KLS-Martin, L.P.

October 1- 5, 2010
ASPS/PSEF & ASMS Annual Meeting
Metro Convention Centre - Toronto, ON Canada

January 14-15, 2011
Basic Maxillofacial Principles and Techniques Course
University of Miami – Miami, FL
Local Host: *Seth Thaller, MD*

January 16, 2011
Challenges of Cleft Surgery in Underdeveloped Nations
University of Miami - Miami, FL
Chair: *Seth Thaller, MD*

February 19-20, 2011
Advanced Multi-Specialty Maxillofacial Course
Lorenz Skills Academy – Jacksonville, FL

August/September 2011
Basic Maxillofacial Principles and Techniques Course
University of Pennsylvania - Philadelphia, PA