rhinoplasty in a comprehensive regimen for correction of nasal deformities. This review describes the most commonly used fillers and their indications in the context of recent reports of both their successes and failures.

METHODS: Retrospective chart review between March 2006 and December 2017. Clinical and demographic features of the patients, technique, satisfaction rates, and complications were recorded.

RESULTS: 135 patients that had undergone nonsurgical postrhinoplasty procedures with dermal fillers were included in the study. We recorded a high satisfaction rate and observed a 7% complication rate.

CONCLUSION: Non-surgical nose augmentation with dermal fillers is an easy, safe, and comfortable technique. It appears that plastic surgeons need to assume a more active role in nonsurgical postrhinoplasty procedures not as a substitute for the revisionary surgery, but as an option in selected patients.

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Bleomycin - A New Drug to Tackle Difficult Vascular and Lymphatic Malformations

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Vascular anomalies are a common occurrence and are found in all age groups and both sexes with equal impunity. All vascular anomalies are categorized into two broad groups namely haemangiomas and vascular malformations. Haemangiomas are vascular tumours with pathologic cell proliferation while malformations on the other hand are comprised of abnormally formed channels within a vascular apparatus lined by endothelial cells that do not undergo cellular turnover. Vascular malformations gradually grow in size with the patient and slowly achieve large proportions involving and displacing the body tissues like muscle, nerve, bone and hence cause difficulties in surgical excision. Advanced vascular malformations are hence a surgical challenge as the surgeon often has to decide between total surgical excision with loss of function as opposed to partial excision while retaining full function. These malformations often occur in a surgically inaccessible location like deep in the palate, behind the maxilla, inside orbit or sometimes engulf a particular area like the perineum and in these circumstances, surgical excision becomes difficult. Many pharmacological agents have been used for treating vascular anomalies and amongst these, bleomycin stands out as the most promising agent for such difficult lesions. Bleomycin has been found to be effective in reducing the size and vascularity of the lesions from 50%-70% over a period of 5–6 sessions. The average dose of bleomycin has ranged from 8–15 IU intralesionally. It is most effective in venous and lymphatic lesions especially those that are large in size and located in deep areas. Patient demographics, lesion characteristics, imaging findings, treatment course, radiological and clinical response to treatment were recorded. Lesions were sub-categorized into venous malformation, including mixed venous-capillary (n=29) or lymphatic malformation (LM) (n = 8). One hundred three out of 112 patients experienced no complications. Local complications included superficial skin infection (n=4), skin necrosis (n=5), hyperpigmentation, and minor contour deformity. There was no recurrence and no systemic side-effects to bleomycin. In conclusion, serial intralesional bleomycin injections can be effective and also safe for the successful management of symptomatic or disfiguring vascular malformations and are a great adjunct to surgery.

Tumescent Anesthesia in Breast Augmentation and Reconstruction: Tips to Make Surgery Easier
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Tumescent anesthesia is useful in liposuction and other plastic surgery procedures because of its great benefits for patients and surgeons. The key to easy access in breast surgery is an accurate technique for dividing or separating anatomic spaces and to avoid pain. In this study, we describe tips to facilitate breast surgery with local tumescent anesthesia that will make the dissection of different spaces easier. As a complimentary issue, we proceed to blocking the last four intercostal nerves with lidocaine 1% with epinephrine. We use Klein solution and Klein needles or any other needle with blunt ending. Submammary incision is always performed.

1. Breast augmentation in subglandular space: Infiltration of local anesthesia is applied to the incision. Then, a little stab is performed in the middle of it to allow Klein needle introduction. After this, tumescent infiltration between the gland and fascia occurs, as if opening a hand fan from medial to lateral.

2. Breast augmentation in submuscular space: A little stab is performed at the incision laterally near the anterior axillar line, through which the subglandular space is infiltrated. After skin incision, the m. pectoralis major is located, and the submuscular space is infiltrated under direct vision. Finding the space between both pectoralis muscles, major and minor, in the upper part of the pocket is as important as in the lower part of it to infiltrate the fascia below the inferior edge of m. pectoralis major for the creation of a submuscular/subfascial pocket without release of the muscle from sternal insertions, maintaining a unit muscle/fascia. This process will create a plinth to hold the implant. The subfascial plane acts as a shelf that gives firmness and stability to the new inframammary fold.

3. Capsular contracture in subglandular breast augmentation: Full capsulectomy is planned through an inframammary incision. Local anesthesia is performed up to the capsule, followed by capsulotomy and explantation. To allow the easy introduction of the Klein needle tip, one inch of the capsule is dissected, and then tumescent infiltration is performed, and the capsule is detached. If the patient has a previous periareolar incision, scar tissue dissection may be difficult at that point. The detaching procedure may be performed either with scissors or with blunt dissection.

4. Immediate breast reconstruction to place a tissue expander: This situation is the easiest one because real anatomy is widely exposed. The m. serratus anterior fascia is very thin and often not easy to dissect. Infiltration starts at an upper level between the m. pectoralis major and minor and then downward, overpassing the pectoralis major edge and creating a submuscular/subfascial pocket again.

These tips make surgery easier and give comfort to the patient, reducing post-operative pain, in addition to conscious sedation or general anesthesia.

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‘Get-Keep-Grow’ Patients Using Geospatial Heat Maps: Successful Practice-Building Via Business Intelligence

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BACKGROUND: Building a new Plastic Surgery practice requires clear understanding of the market- its needs, size, demographic, psychometric-data, current referral patterns and capacity for new growth. New graduates are neither taught to obtain, extract, and analyze this type of data, nor do they ever learn how to identify actionable insights based on this data during training. Here, we apply one such method towards practice-building in Central Ohio. Geospatial mapping identifies clusters and