FROM THE PRESIDENT

The mission of our organization is to advance the science and practice of maxillofacial and craniofacial surgery. We certainly accomplish this through education and research by means of multiple courses, research grants, our annual meeting etc. Also stated in our mission statement is the concept of advocacy on behalf of our patients and our members. The word advocacy is defined as providing active support on behalf of an idea or cause. To many of us this conjures up the process of lobbying and wheeling and dealing that goes on in Washington in order to get certain bills passed or more commonly to get them defeated. Yet, it also means working with other organizations with similar goals and intents in order to get an idea, a cause, a program, a process moved forward.

In years past ASMS has worked with several organizations including ASPS and the AMA on various forms of legislation.

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Editor’s Column

Welcome to the Spring Edition of the ASMS Newsletter. Thanks to our Newsletter Committee and Guest Contributors, each edition of the Newsletter has provided new content and serves to highlight the key issues facing practitioners in our specialty. As a result of these efforts, online access to our Newsletter continues to remain at an all-time high. Due to our open access policy for all plastic surgeons, our effort to disseminate information pertinent to the practice of maxillofacial surgery is amplified further among plastic surgeons who are not presently members of the ASMS. Online statistics bear this out: In the month following release of the Fall, 2012 Newsletter, there were over 2000 hits to our Newsletter site; 2000 of these hits were through Open Access, and 5 hits were through our Members’ Only site. In the month following release of the Winter, 2013 Newsletter, there were over 600 hits to our Newsletter site; 600 of these hits were through Open Access, and 10 hits were through our Members’ Only site. Clearly Open Access has generated a huge enthusiasm for our content, and can only serve to increase awareness in our specialty. We hope that this will translate into increased participation in all activities of the ASMS, including increase in the number of Active Members of our organization.

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Editor’s Corner (continued from page 1)

For the remainder of this column I wish to address the importance of working with other members of our specialty and the impact that this can have in shaping our careers as plastic surgeons.

Ken Salyer, a Past President of the ASMS and the Kazanjian Lecturer for the 2013 ASPS/PSF/ASMS meeting, provides insights into the value of post-graduate fellowships and associations in shaping one’s career. His upcoming book, “A Life that Matters” (Hachette Publishing, New York) highlights the role of fellowship and camaraderie in his career development.

Dr. Salyer started his career as a plastic surgeon with an interest in academics and research, but it was only through visiting fellowships and the camaraderie that ensued that his focus was directed towards cleft and craniofacial surgery. Towards the latter months of his residency training in plastic surgery in 1969, Dr. Salyer was awarded the Earle Padgett Visiting Fellowship, providing him a one month opportunity to visit centers of his interest. During that month, Dr. Salyer visited Roswell Park (Vahram Bakamjian), New York City (John Converse, Donald Wood-Smith, Gustave Aufricht, and Richard Stark), Rochester (Bob McCormick), Miami (Ralph Millard), and Palo Alto (Bob Chase and Don Laub). What might have seemed to be an overwhelming month left a significant impact on the young Dr. Salyer. He took a position to initiate the plastic surgery unit at UT Southwestern in July, 1969, from where he continued to correspond with his newly found mentors.

The brief visit with John Converse and Donald Wood-Smith played a major role in shaping Dr. Salyer’s career focus, and he had an ongoing exchange with both individuals through reciprocal visits thereafter. The value of travelling fellowships in Dr. Salyer’s career was further amplified the following year when Paul Tessier was invited to the United States as the Kazanjian Visiting Professor. After observing the master do a cranial vault remodeling and Le Forte III advancement on an adult patient with Crouzon Syndrome, Dr. Salyer took the techniques back to Texas where he continued to develop his own technical contributions to treat this patient population.

Tessier’s impact on Dr. Salyer continued and in May 1972 he went to Paris for a week long symposium held by Dr. Tessier. Here he met Daniel Marchac, Fernando Ortiz-Monasterio, Linton Whitaker, Ian Munro, Ian Jackson, and Jack Mustarde’. The first 5 of these individuals went on to form a life-long travel club, often referred to as “The Band of Brothers.” This set of circumstances, initiated by travelling fellowships and the camaraderie that can be cultivated from these fellowships, is one of the best examples of the value that such activities can take in shaping one’s career, and subsequently the specialty in which we focus.

Trips to serve the underprivileged also provide an excellent opportunity for us to exchange clinical skills and ideas with our colleagues. In this issue, Jordan Steinberg, a senior resident in plastic surgery at Northwestern University, has written about his recent trip to Assam, India as a Regan Fellow of Operation Smile. The enthusiasm that Dr. Steinberg reflects in his article is reminiscent of the enthusiasm that Dr. Salyer reflected upon completion of the Earle Padgett Visiting Fellowship in 1969. I had the good fortune of accompanying Dr. Steinberg to Assam. My colleague, Don Mackay and his chief resident, Cathy Henry, also participated in the trip (see photo).

While Dr. Steinberg provides great insight into the value of the trip from the resident’s perspective, the process of education was also taking place at another level. Dr. Mackay and I learned a tremendous amount both from one another and from the surgeons in Assam for whom cleft surgery is their primary focus. Experiences such as this one are an unspoken byproduct of the camaraderie that we cultivate with our colleagues in the ASMS.

The ASMS Education Committee, led by Frank Papay, has initiated an effort to develop a list of ASMS mentors who would be willing to host fellow ASMS members to observe them in areas of our specialty in which they have developed a special niche. As I have highlighted in this column, such relationships can have tremendous impact in shaping our careers, even though many of us have developed established practice patterns. I hope that all of us will have the opportunity to benefit from this aspect of the ASMS and continue the spirit of lifelong learning that is a recurrent theme as we reflect on the career of individuals such as Ken Salyer and other leaders in our specialty.
Reflections from Guwahati

Jordan P. Steinberg, MD, PhD
Northwestern University Medical Center, Chicago, Illinois

“You must become the change you want to see.”
- Mahatma Gandhi

Sometimes in life we have the privileged opportunity to take part in an experience so transcendent, so rich in meaning and virtue that we’re drawn to reflect on our own daily practices and how we may, by incorporating even just a few elements of what we’ve just witnessed, achieve higher and greater. Such is my conclusion from a most influential one-week visit to the Guwahati Comprehensive Cleft Care Center (GC4) in Assam, India as a Regan Fellow through Operation Smile.

The state of Assam is located in the remote northeastern region of India, separated from the mainland by a narrow stretch bordered by Nepal to the north and Bangladesh to the south. Guwahati is the largest city in Assam and one of the largest in all of the Indian northeast. Efforts three years ago by Drs. Alexander Campbell and Carolina Restrepo, in conjunction with Operation Smile and the government of Assam, led to the establishment of a first-of-its-kind comprehensive cleft care center in Guwahati. Assam was first identified as a target site for establishment of a first-of-its-kind comprehensive cleft care center in Guwahati. Assam was first identified as a target site based on Indian demographic estimates that indicated the highest concentration of unrepaired cleft lips and palates in the country (and perhaps the world). A goal was established to repair some 30,000 clefts in Assam. Progress toward this goal has been truly remarkable, and I’m pleased to say that during my week at GC4, I witnessed the 5,000th case to be completed in the three years since the center was founded.

During my week, I took careful account of what it is that makes GC4 so truly special. First, the staff, including everyone from nurses to scrub technicians to volunteers to the surgeons, are an incredibly congenial, spirited, and dedicated bunch. They exude a terrific sense of pride and devotion to a humanitarian cause that is, quite simply, palpable. There is no cynicism, no shift work mentality, no forestalling of cases for lunch breaks or other interruptions, and none of the pressures or stresses that occasionally hamper large missions. GC4 is a well-oiled machine with efficient utilization of limited resources and a model not only for cleft care in other parts of the developing world, but for healthcare in general. Patients are promptly evaluated and scheduled for surgeries with the aid of translators who speak the local dialects of Assam or neighboring Meghalaya. They are pre-admitted the day before surgery in a single ward of Mahendra Mohan Choudhury Hospital of Guwahati. On a typical weekday, surgeries are performed on four to five operating tables arranged in parallel in a single large room. Anesthesiologists may maintain close attendance on four to five operating tables simultaneously, and surgeons or their assistants may peer over to the neighboring table to quickly observe an interesting finding or offer technical advice. Turnovers are rapid and efficient. Post-op patients are admitted to the ward typically for a one night overnight stay.

A particularly special and rewarding experience was morning rounds on the GC4 ward to check on the post-operative patients from the prior day. Despite the patients’ inability to communicate directly with us given the language barrier, their new smiles were words enough. The walk up and down the ward each morning was simply unforgettable. And the best part of completing rounds for the post-op patients was the realization that patients at the other end of the ward, in the pre-op area, would have their opportunity as the next group. Team morale at these moments was exceptionally high, as was the sense of empowerment and fulfillment.

GC4 is a place with incredible surgical talent and results that appear to rival the best of cleft centers in the developed world. The passing of surgical knowledge and expertise from Drs. Campbell and Restrepo to local Indian and Assamese surgeons and their subsequent successes is a true testament to the model that has been established.

I had the good fortune of spending time with Dr. Gaurav Deshpande, a talented and dynamic full-time GC4 surgeon who, to date, has performed over 800 cleft repairs in his first year at the center. Visitors from all over the world have come to GC4 to share their knowledge and pearls of cleft surgery since the original opening of the center.

I am indebted to my mentor, Dr. Arun K. Gosain of Lurie Children’s Hospital of Chicago, as well as Dr. Donald Mackay of Penn State Hershey Medical Center, for making this trip possible for me and their superb insight and instruction during the week.

I also thank Drs. Alex Campbell and GC4 director Dr. Mark Schoemann for helping to coordinate our activities this week and for their instruction. Finally, I was happy to share in the experiences this week with Dr. Mackay’s resident from Penn State, Dr. Cathy Henry.

I’d like to conclude by encouraging interested residents or fellows to visit GC4 and partake of this wonderful opportunity themselves. Regan and Stryker fellowships are available through Operation Smile for brief trips. Long-term opportunities for training are now also available at GC4.

As GC4 has become a model center, we only hope that others of its kind will be constructed in areas of high priority in the future, both within India and elsewhere throughout the world.

Sometimes in life we have the privileged opportunity to take part in an experience so transcendent, so rich in meaning and virtue that we’re drawn to reflect on our own daily practices and how we may, by incorporating even just a few elements of what we’ve just witnessed, achieve higher and greater.
A Community Trauma Center, Maxillofacial Surgery and the Economy

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In a timely manner, I recently received a copy of the ASPS 2012 procedural statistics. As I note last year the treatment of “Maxillofacial Surgery” patients has once again increased. The number of maxillofacial surgery cases reported in 2011 was 192,000 and the number of reported cases in 2012 was over 209,000 cases. These numbers include both facial fractures and facial lacerations. This does not cover congenital deformities or head and neck reconstruction, which are listed separately.

I thought that with a downward turn in the economy and a struggling cosmetic surgery market there might be a correlation with the increasing maxillofacial surgery cases reported, and the struggling economy.

In our region of New Jersey, it seems like every physician and/or surgeon is performing cosmetic surgical procedures. This includes gynecologists, family practice physicians, as well as dentists. However, there are few surgeons who are willing to treat facial trauma and facial fractures.

At our institution at Jersey Shore University Medical and Regional Trauma Center, a majority of the facial trauma reconstruction is performed by plastic surgeons. None is performed by otolaryngology and isolated mandible fractures are treated by oral surgery. As the chief of the division of plastic surgery, I have the opportunity to review and take part in the credentialing of new plastic surgeons, along with the re-credentialing of the established staff.

At our institution we have over thirty plastic surgeons on staff. Most have full active privileges, with few having regional privileges. Due to the large number of active plastic surgeons on staff, the Trauma/Emergency Room Call Schedule is elective for those who are willing to accept the responsibility. Those surgeons who choose to participate are required to be available to cover the Emergency Room and Trauma Service along with elective hospital house ward and clinic consults, 24 hours/day, for one continuous week, two weeks per year.

As I mentioned in a previous article, our institution does not have any plastic surgical or general surgery resident coverage. At this time, all of the plastic surgeons on staff are in private practice and there are no hospital employed plastic surgeons. Most are in solo practice, with two groups of surgeons. I mention this because hospital coverage can be hectic and demanding for a solo practitioner especially during the summer months when the population of the Jersey Shore probably doubles.

Ever since 2008 when the local and national economy declined, more plastic surgeons have requested to participate in emergency room and trauma call schedule. Trauma call for plastic surgeons is essentially “Maxillofacial Surgery cases”, with a small number of lower extremity trauma cases. The Emergency Room call cases are basically lacerations on children, however my observation has reported an increase number of “dog bite” injuries.

When our division initially developed an elective hospital call schedule, the thought was that there would not be enough plastic surgeons willing to cover the hospital during the year. The initial thought was that most of the plastic surgeons would choose to electively remove themselves from the schedule. However, in actuality, the opposite has occurred since 2008. With over 26 plastic surgeons who voluntarily elect to cover the hospital, both new plastic surgeons along with the established staff has increasingly chosen to electively cover the hospital emergency call schedule. Routinely I receive emails from other well-established plastic surgeons, with years of service to the hospital requesting additional weeks of hospital emergency call if available, or if any surgeons want to “give up” call during the year.

I know that this must be hard to believe for most “academic surgeons” who rarely see patients in the emergency room or actually know where the emergency room or trauma area is in their hospitals. The community trauma center is a different world than experienced by the academic plastic surgeons. Not only does the on call plastic surgeon actually come into the emergency room on weekends and in the middle of the night, we also get our own consents from the patient or family, dictate our cases and enter post-operative orders into the computer. I have been on staff at my institution for over 20 years, and I still voluntarily participate in the hospital emergency schedule. In my individual case, my office does not schedule any elective cases during that designated week. It is my personal observation that the downturn in the economy since 2008 has kept the community plastic surgeon on the hospital emergency room schedule, providing service to both the hospital, as well as the community in which we live.

The community trauma center is a different world than experienced by the academic plastic surgeons.

CORRECTION and UPDATE: Marchac Obituary

In the Winter issue of Maxillofacial News, the obituary published on Daniel Marchac included material provided by Drs. Linton Whitaker, Bryant Toth, and Scott Bartlett. Plastic and Reconstructive Surgery (PRS) has also published an obituary on Dr. Marchac, authored by Drs. Whitaker, Toth, and Bartlett, in the May issue.
Clefting of the palate is a frequent condition treated by the craniofacial surgeon. Multiple CPT codes exist for the repair of cleft palates. These codes are separated into either a primary or secondary repair code. Currently, 4 CPT codes are described for primary repair and 9 CPT codes exist for secondary repair. This CPT coding corner will address primary repair and next newsletter’s article will address the secondary repair codes.

Primary cleft palate repair has 4 CPT codes assigned to it (42200, 42205, 42210, and 42235). Likely the most commonly used CPT code for repair of cleft palates is 42200, palatoplasty for cleft palate, soft and/or hard palate only. The description associated with this code states that the physician repairs the developmental cleft opening of the palate with closure of the opening between the oral and nasal cavities with a partition of soft tissue. This code includes the relaxing incisions, elevation of the soft tissue, development of the mucosal and muscular layers and closure in layers. Per this code description, it should be noted that the cleft size and location will dictate the type of repair to be performed and this code encompasses all types of repair whether it be an intervelar veloplasty, Furlow double opposing z-plasty or other described technique. CPT code 42200 covers closure of Veau I, II, III and IV type clefts.

CPT codes 42205 and 42210 involve closure of the alveolar ridge in addition to palatoplasty. CPT code 42205 is described as palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only. Both of these codes describe closure of the hard and soft palatal tissue by development of tissue planes and closure in layers. These codes differ from 42200 in that they address the closure of the alveolus. The additional description for this code states that incisions are made in the palatal mucosa adjacent to the alveolar bone with closure with single layer closure in the gingival incisions. Like most CPT codes that involve bone grafting, the harvesting of the graft from the donor site and closure of the donor site is incorporated in the 422100 and should not be unbundled. Essentially, codes 42205 and 42210 should be used when alveolar repair occurs during primary palate repair with or without a bone graft. These codes do typically carry a higher RVU value than 42200.

Code 42235 (repair of anterior palate, including vomer flap) differs from the previously described CPT codes in this article by the fact that it only addresses the hard palate. The narrative for code 42235 read a combination of mucosal and mucoperiosteal flaps are used to repair the defect with development of a mucoperiosteal vomer flap being sutured to the mucoperiosteum of the hard palate (for closure of the nasal side). The oral side is then closed with a resultant layer closure. Some surgeons prefer to repair the cleft in stages with the soft palate repaired at one age and the hard palate at a later stage to in order to minimize mid-face growth deficiency. In this instance, the CPT code 42235 would be employed for this second stage. Code 42235 should not be coded in conjunction with 42200.

Colleagues and Fellows Pay Tribute to Henry Kawamoto, MD

This year marked the retirement of Past ASMS President Dr. Henry K. Kawamoto, Jr., a legend in the field of maxillofacial surgery. Over New Year’s weekend, UCLA’s Dr. Reza Jarrahy and USC’s Dr. Mark Urata – both former “K Fellows” – organized a surprise black tie dinner for previous fellows and international friends in Dr. Kawamoto’s honor.


When his long-time nurse, Toni Ellis, was asked how Dr. K was handling retirement, she noted that he did three cases in the office the past week.

His daughter, Michelle Kawamoto, chose the wines for the evening and provided humorous anecdotes of growing up in the Kawamoto family. And Drs. McCarthy and Wolfe offered warm reflection about the career of a surgeon whom the maxillofacial community has come to respect and admire.
Panel Discussion: Facial Reanimation PART TWO
Panel Moderator: Jeffrey Marcus, MD
Panelists: Gregory Borschel, MD, Arun Gosain, MD and Michael Klebuc, MD

The first part of this discussion appeared in the Winter issue of Maxillofacial News.

Jeff: I wanted to do something that is a little different than maybe what has been done in the prior teleconferences. I have three residents that have some questions that they would like to ask. Is that okay with you all?

Everyone: Sure! No problem!

Jeff: Okay, the first resident we have is Mark Fisher, and he has a question for the three of you.

Mark: Good evening everybody. My question is, with respect to tone, I get the impression that the resting tone that you appreciate in the patient’s face is a very important issue, but I wonder. Is there one approach versus another that seems to achieve better overall tone, cross face versus masseter for instance?

Mike: I will start off because this has been an area of interest to me. The masseter-to-facial nerve transfer can create very nice excursion of the commissure. It often matches the contralateral side. The masseter nerve has a large number of motor axons. In fact, Greg published a nice paper looking at the motor nerve axon counts. Greg, if I remember correctly the nerve has around 2700 myelinated fibers.

Greg: Yeah, that is right!

Mike: So, it has a very dense population of myelinated motor fibers that can create a significant amount of excursion. At the same time, there can be some lack of dynamism and resting tone when the V-VII transfer is used alone. It may be that the masseter nerve has less resting, baseline neural output than the facial nerve and is less effective in restoring tone. The dynamism and resting tone can be significantly improved by combining the V-VII transfer with cross face nerve grafts. With the combined technique about 50% of the smile is spontaneous coming from the cross face grafts. The patient can then activate the masseter transfer to create a more powerful smile. With physical therapy and neuromuscular retraining, they can make very natural looking facial expressions.

Jeff: Gentlemen, another of our residents, Duncan Hughes, would like to ask a question on that topic.

Duncan: Hello! So, my question was with the masseter.. does the patient actually have to go through occupational therapy, and do they have to bite down to get that extra excursion in a social situation?

Mike: The motion you get with a V-VII transfer can become more effortless or reflexive in time. But it’s never truly spontaneous. We have found that about 70% of patients at the 2 year mark will be able to create a smile without clenching their teeth together, and as Arun eluded to, the younger the patient, the easier the adaptation seems to be. I think also in your pre-operative consultation, it is very important to try to ascertain how committed the patients are to practicing. If you have an older patient, but they are very motivated and are willing to sit in front of a mirror for a half an hour a day and practice, then there is potential for a good result. If the individual is not willing to put in that time and effort, then they won’t achieve the optimal outcome. I explain it to the patients this way. I say, the nerve transfer is like an instrument and you have to learn how to play it. Even if someone gives you a Stradivarius and you don’t practice, it is not going to sound good. So, they have to make that commitment upfront. I think it is very important.

Arun: In children, we have used a biofeedback program. We work with our therapists who run the biofeedback program to help the children to develop a symmetric smile that is socially acceptable. The important point is to achieve symmetric excursion between the operated and un-operated sides.

Jeff: Dr. Alexander Allori also has a question, another one of our residents.

Alexander: Hi! Thanks for this panel. I really enjoy it! My question is about short and long term outcomes, specifically what you might be considering to be the most important functional aesthetic and psychosocial outcomes and if you have any proposals for how they should be measured, for example, static and dynamic stereophotograhy comes to mind. So, I would like to hear your thoughts on that.

Greg: I can address some of the outcomes and issues. I think one thing that sort of gets neglected a little bit and maybe this conversation will stimulate research in this regard is how the patient feels about it, whether it was worth it, what do the families think, and looking at things from a qualitative aspect. There have been a number of studies looking at measurements from the Toronto group there has been a series looking at the excursion of the muscles and where the oral commissures go and so forth. Not a lot of work surprisingly has been done on those qualitative aspects because in the end, what really matters here is ultimately patient satisfaction right?

Everyone: Yeah! Right!

Greg: I know I haven’t really answered your question, but I have kind of answered your question with a question, which maybe isn’t fair. I think another area that people have started to look at is what is going on in this central nervous system, is there evidence of transference of the motor sensors between 5 and the 7th nucleus. So far, it looks like there is some evidence that it does actually occur.

Alexander: That is an interesting thought I haven’t thought about. Have you tried dynamic stereophotogrammetry?

Jeff: I have not.

Greg: We are just starting to get into now.

Jeff: I want to just say that I appreciate everybody taking the time out tonight and even getting it out towards the late part of the evening, but what do you think will be the best advances within the next 5-10 years? What do you think we ought to be putting our focus into?

Greg: I would like to see our cross facial nerve grafts become more effective at driving greater amplitude in excursion in these transfer

(continued on next page)
Jeff: of objectively assessing facial reanimation patients. The development of a long nerve allograft that could be used for cross face nerve grafts. Also, there is some very interesting work going on with synthetic muscles. I believe the material that was first made for NASA. It is an electroactive polymer that can respond to electric charges and contract much like a muscle. It will be interesting to see if these materials give us some robotic way to treat facial paralysis.

Mike: One thing I would love to see happen in the next 10 years is the development of a masseter versus a cross face nerve graft is that I know the muscle will be much more powerful innervated with the motor nerve to the masseter. So, I think that there are some things going on in our lab and other labs elsewhere that may help with this problem, looking down maybe a couple 5-10 years in the future.

Arun: From a technical point of view, I think it would be nice if we had a muscle that could preferentially activate the different areas of paralysis. There has been some anatomic work looking at differential activation of segments of the serratus anterior. However, there has not been much clinical work to apply these findings. This would be an interesting question particularly because the lower lip has not been addressed as well as the upper lip. In cases of bilateral paralysis affecting bilateral speech sounds, elevating the lower lip to meet the upper lip would be vastly improved if we could innervate and reanimate both at the same time. In terms of outcomes, we have looked at the question of cortical plasticity and documentation of this plasticity with FMRI. However, the ability to distinguish between cranial nerves V and VII has been difficult with FMRI because the nuclei of these nerves are too close and localization is hampered by motion artifact. Our ability to follow cortical plasticity objectively may evolve as FMRI techniques evolve. In addition, we mentioned the outcomes and the psychological impact of facial reanimation. As we develop instruments to assess the psychological impact, such as what Karen Wang and her group in Toronto is doing for cleft patients, we should develop a similar means of objectively assessing facial reanimation patients.

Jeff: Last question and then I will let you guys all off the hook. Do each of you have a question that you would like to ask the rest of the panel?

Arun: I have two questions that remain unanswered: 1) Does anyone have the experience either with the serratus anterior as a regionally innervated muscle? 2) Has anyone used FMRI as a means for distinguishing between the activity of cranial nerves V and VII?

Greg: I would say with respect to the FMRI, we are looking at it now and I can’t tell you the results because they are ongoing, and I have no experience for the Serratus-anterior.

Mike: I know the Bunkie group in California had a lot of experience with the serratus anterior muscle during the 80s and 90s but is does seem like most surgeons have trended away from that donor site.

Mike: I would be interested to know everybody’s philosophy for trying to anchor free muscle flaps in the commissure and upper lip? I have changed up the technique I have used significantly since I trained with Ron Zuker.

Greg: What did you do Mike?

Mike: I try to make a real effort to advance the muscle all the way to the mucosa of the commissure, and I also try to bring slips of the muscle right into the obicularis in the upper lip. I think I am able to get a little more motion that way and more elevation of the upper lip.

Jeff: So, it sounds like you are going a bit more medial than you were with Ron?

Greg: That’s right. We used to anchor the gracilis more toward the lateral border of the obicularis. I still anchor it to the obicularis oris but I am also trying to get fixation as medially as possible without creating dimpling in the vermilion.

Jeff: One of the things that I think makes the difference is the age of the patient and whether they lost function or whether the condition is congenital. The congenital patients don’t have any muscle at all. The previously innervated patients have muscle depending on how long times have been. When there is an obicularis that is present, I think that you can tie into it, but you do want to get way more medial than I ever thought you needed to before. I think the congenital patients are challenging because there is no obicularis native, and you do still need to get way more medial than we all thought we needed to be.

Greg: I agree. Even now, I try to get as medial as I can basically, but maybe I should be going more medial.

Mike: If you are trying to create dental show I think it’s important to have a more medial and more vertical muscle orientation. I am interested to know to what extent you guys are thinning the muscle and if you weigh the muscle?

Jeff: I don’t weigh it, but I am much more aggressive at fitting the muscle now than 10 years ago. I would have been concerned 10 years ago with being this aggressive at fitting the muscle, but I think that one of the errors that we have made is that we have just had too much muscle bulk that has created unfortunate asymmetry.

Greg: I agree. I mean, now 5 years, I am thinning the muscle way more than I was when I started out. I try to do most of it in-situ, and I stimulate as I am going, and I try to coagulate as I am going. We weigh the muscles so we have kind of noticed a trend over time that we are getting smaller and smaller muscles. I think it probably has helped for the bulk, and again, we haven’t actually measure this with 3D photos or anything, but it would be nice to do that. No question.

Jeff: Greg, when you are thinning the muscle, we all split the gracilis longitudinally, but are you now thinning the superficial surface as well?

Greg: I am now thinning everything that I possibly think that I can thin without damaging the muscle.

From a technical point of view, I think it would be nice if we had a muscle that could preferentially activate the different areas of paralysis. There has been some anatomic work looking at differential activation of segments of the serratus anterior.
Basic Maxillofacial Principles and Techniques

August 9-11, 2013
University of Pennsylvania
Philadelphia, PA

Please visit the ASMS website at www.maxface.org for a complete listing of all upcoming courses and to register.
From the President (continued from page 1)

This includes legislation so that insurance companies will stop denying surgery for certain cleft and craniofacial patients. This legislation, called Reconstructive Act, is still ongoing and further work needs to be done. How much have we done of late in regard to advocacy? Admittedly, not enough. The AMA had its House of Delegates meeting in San Diego a few months ago. We were fortunate to have Vick Lewis, past president of ASMS, as the Chair of the Plastic and Maxillofacial Surgery section of the AMA. At that meeting the Oral and Maxillofacial Surgeons had a resolution proposal with respect to scope of practice. They petitioned the right of single degree OMS to practice Facial Aesthetic Surgery. After discussion in the House, the resolution was soundly defeated by over 80% voting members who included not only our group but also the Ophthalmic Plastic Surgeons and the Facial Plastic Surgeons. This is an example of strange bedfellows or simply cooperating on a cause that makes sense.

A lot of legislation is coming down the pike, much of it under the frame of Obama Care. Not only do we need to understand the structure and consequences of these forms of legislation but we have to decide whether it is appropriate for our members, colleagues and in particular for our patients. We are a small society and at times it is very daunting to consider what can be done in the face of all these changes coming from Washington. What we need to remember is that effective change occurs at the state and local level. It is here where we can make a difference and we need to lobby at that level for what is right for our patients. Another way that we can be effective is to join other organizations that have similar interests, goals and objectives. It is disappointing when we see situations where sister organizations come out publicly and indicate that they cannot work together. This only adds fuel to those other competing organizations so that they can take advantage of this apparent display of weakness and lack of union. ASMS has had for many years a very good relationship with its sister organizations including ASPS, ASAPS and PSF. We share many things in common, we are all board certified plastic surgeons, we adhere to the highest level of practice standards, and we believe that training and education is the vehicle to good and competent practice. We also believe that progress in the field can be made only with proper research and education. For over 30 years we have been conducting our annual meeting along with the ASPS and the Educational Foundation. We have been successful in providing a high level of quality in the scientific educational and research arenas to this annual event. This year will be no different. Our next newsletter will actually go into detail regarding the Preconference Symposium, free papers, panels, instructional courses and other events that will be put on by ASMS and its members.

Most recently we had our newest educational workshop at the state of the art facility at LSU in New Orleans. This course is a unique cadaver-based facial aesthetic, hands-on workshop that has been highly praised by all participants. Experts in facial aesthetic surgery demonstrate their techniques on fresh cadavers working with the attendees. We hope to make this a joint venture with shared value. We want to make this course more accessible not only to our members but also to members of ASPS, ASAPS and other legitimate board certified plastic surgeons and qualified residents. Like this we will be discussing other possible collaborative efforts where we can not only share our expertise with those of other colleagues, but also make these courses more effective in regard to time, content and cost.

Advocacy, then is not just going to Washington in order to lobby and talk politics. It also means working with our sister organizations, our colleagues both nationally and locally. It means taking an idea, a cause, a program and uniting behind it so that it can be moved forward. If there is a cause or an idea that you feel we need to work on please contact me so I can work with you and others in evaluating it and then trying to make it happen. The Kentucky motto in our seal says: “United we stand, divided we fall”.

ASMS AWARDS DEADLINE: AUGUST 16, 2013

CRANIO (Craniofacial Region Added New Information Opportunity) Fellowship Program

Research Grant Awards

ASMS Resident Scholar Program 2013

All Award Recipients are expected to attend the ASMS Annual Meeting in San Diego, October 10-13, 2013 to accept their awards.

Applications and additional information: www.maxface.org
Book Review: **Rhinoplasty**  
by Bahman Guyuron, MD  
Publisher: Elsevier Sciences

Review by Ali Totonchi, MD, Assistant Professor  
Medical Director of Craniofacial Deformity Clinic, Plastic Surgery Division, MetroHealth Medical Center, Case Western Reserve University

*Rhinoplasty*, by Dr. Bahman Guyuron is a comprehensive, single-author rhinoplasty textbook, which is meant to put the author’s thirty years plus of expert professional experience and perspective into the hands of its reader. The insistence of the author to write each chapter of the textbook himself reflects his dedication to precision and first-hand transfer of his knowledge and expertise to his readers with this book.

This book is written in twenty-one chapters and is available in both print and E-book versions; the book begins with anatomy and patient assessment chapters and goes on to review the most common issues encountered in rhinoplasty practice. It ends with chapters addressing ethnic rhinoplasty, management of the common complications, and migraine headaches. All chapters integrate the use of valuable learning tools, which include high quality standardized pre and post-operative pictures, 3d animations, illustrations, and videos, which provide the reader with visual aides to better understand author’s innovative surgical techniques. The book’s consistent picture quality with 4 standard views is impressive and the 3d animation selections are designed to provide the reader understanding of the overall effect of the single surgical maneuvers on other parts of the nose. The videos are sequential by design such that if you view them in order, they show a rhinoplasty surgery from start to finish, utilizing the author’s signature methods.

The book’s strengths lie in its ease of reading, the multifaceted range of instructional methods to facilitate the transfer of knowledge (professionally designed animations, illustrations, pictures, and movies). Great attention to details in this book certainly goes along with the personality which is expected from a great rhinoplasty surgeon.
Case Study: Treatment of Secondary Complications Following Frontal Sinus Fracture

Sean Boutros, MD, Houston, Texas

HISTORY
DH is a 46-year-old female with a history of motor vehicle accident 6 years prior. This resulted in numerous facial fractures, which were treated at an outside institution. She underwent reconstruction of the frontal sinus with placement of hydroxyapatite. She subsequently developed an infection with a draining sinus in the area of the radix. Analysis of the sinus drainage showed septated hyphae. The drainage resolved with long term oral antifungal therapy. Since that time, the patient has had chronic fatigue with decreased energy and difficulty with the activities of daily living. She had seen numerous physicians for these underlying symptoms. On seeing an immunologist, the patient was found to have depressed IgG levels. She received monthly gammaglobulin transfusions. Post-transfusion, she had increase in her energy, which lasted for approximately 3 to 4 weeks. On her initial consult, she had been undergoing gammaglobulin transfusions for 3 years.

Clinically, she had a small depression in the glabellar area with no evidence of erythema, abscess formation, or further drainage from the sinus tract. CT scan showed an anterior bony deficit with opacification of the frontal sinus.

The patient’s goals were to improve the appearance of the glabellar area and possibly resolve any underlying infection.

DISCUSSION
This case represents a common diagnostic and therapeutic dilemma. Often, as plastic surgeons, we are presented with patient with ambiguous complaints. These patients are, as with the patient in this case report, often passed from doctor to doctor and dismissed as psychologically imbalanced or drug seeking. This patient has a clear history of a complicated infection after treatment with hydroxyapatite. She also has objective findings of a gammaglobulin deficiency with improvement in the symptoms following gammaglobulin transfusion. This, together with the history of infection and the cosmetic complaints, urges us to take a closer look to see if there is a truly underlying issue that can be corrected.

In order to treat an area of chronic infection, principles include removal of all contaminated material or tissue followed by replacement with well-vascularized tissue. In this case, the patient was missing anterior frontal bone and had hydroxyapatite in the frontal sinus. She required removal of all foreign material and reconstruction with vascularized bone.

TREATMENT
The options for vascularized bone are limited. While microvascular procedures have become the mainstay, local options do exist. In this patient, the prior coronal flap was made more anterior than is typically done; therefore, the superficial temporal vessels were spared. We elected to reconstruct the frontal area with a vascularized clavicular bone flap based on the superficial temporal vessels.

She underwent resection of the involved portion of the frontal bone and removal of the underlying hydroxyapatite followed by replacement of the anterior frontal bone with a vascularized calvarial flap. The bone was taken in a way to match the defect created by the debridement and secured it to the frontal area with mini-plates.

RESULT
The patient recovered from the procedure uneventfully. She did have a small area of alopecia over the donor site, which was easily covered by her hair. The contour of the frontal bone was excellent. Furthermore, she had normalization of her IgG levels with complete resolution of her chronic fatigue. The patient subsequently returned to her prior employment with requiring no more medical treatment and complete resolution of all of her prior complaints.
Residents and Fellows Corner: Now is a Great Time to Pursue a Career in Craniomaxillofacial Surgery

Carolyn R. Rogers, MD
Boston Childrens Hospital, Boston, Massachusetts

If you are a resident or fellow reading the ASMS newsletter, you are probably interested in craniomaxillofacial surgery. Congratulations! You are considering joining an exciting field brimming with possibility. Despite the many rewards of this field, there is a strong chance that somewhere along the way colleagues have discouraged your interest, citing lack of opportunity. This is a discouraging, but common, scenario for residents. Despite this, there is a lot going on in craniomaxillofacial surgery and the ASMS is here to demonstrate it!

As you can see from reading this month’s newsletter or attending an ASMS course or symposia, there are exciting advances developing in the field of craniomaxillofacial surgery and a demand for fellowship-trained surgeons in a variety of practice settings.

At the inception of the specialty of craniomaxillofacial surgery, there was a backlog of patients waiting for a surgeon with this unique skill set. Over half a century later, this backlog no longer exists in developed countries and procedures such as fronto-orbital advancement, facial bipartition, or mid-facial advancement are performed infrequently. Nevertheless, in their place, an array of research-driven surgical techniques have developed that continue to transform our specialty. For example, since the early days of craniofacial distraction osteogenesis, we have a better understanding of its long term results and have expanded its indications/applications. Complementing this is our ever improving understanding of bone biology and bone substitutes. In addition, the last decade has brought composite tissue allotransplantation into the realm of craniofacial anatomy lends itself well to facial soft tissue reconstruction. With the rapid advances made over the last few years, no doubt it will become an even more significant part of craniomaxillofacial surgery in years to come. If advancing the discipline clinically or through research piques your interest, the ASMS will help you get involved by offering courses on cutting-edge topics or by funding maxillofacial research.

Residents often as the question, “are there jobs in craniomaxillofacial surgery?” If you are interested in applying your skill set broadly, indeed, there are. For the budding craniofacial surgeon primarily interested in pediatrics, dedicated children’s hospitals are cropping up all over the country. With them comes a demand for practitioners with subspecialty training. Cleft surgery, for example, was once within the purview of general plastic surgeons. Nowadays, patients and children’s hospitals demand fellowship-trained surgeons who focus on pediatric issues. For the resident or fellow interested primarily in adult craniofacial surgery, there will always be a demand for your abilities, particularly in the realm of facial trauma. Facial trauma skills mutually complement the orthognathic practice you may choose to build after fellowship. Moreover, proficiency with surgical approaches to the face and craniofacial anatomy lends itself well to facial soft tissue reconstruction, such as for cancer reconstruction or facial aesthetic surgery.

In terms of actual craniofacial job availability, as with every other area of plastic surgery, it depends largely on the specificity of your search criteria and breadth of your training. If you only will consider a pediatric craniofacial position in a specific location, yes, you will have a hard time finding a job. But, if you are willing to look broadly and apply your skills creatively, you will be in much better shape. Review of advertisements over the last year demonstrated at least 13 academic craniofacial positions and a handful of craniofacial surgery positions at academic affiliate hospitals and large HMO/group practices. Amongst these, there was a strong interest in surgeons with maxillofacial/orthognathic training. There may also be positions created for the right person at the right time or positions not exclusively dedicated to craniofacial surgery where your skill set will still be a huge asset.

The ASMS is here to help you develop your career in craniofacial surgery. The ASMS website provides one of the most comprehensive job listings for craniofacial surgeons. In addition, the various courses, events, and visiting professor programs hosted by the ASMS are a fantastic opportunity to get inspired and advance your education while networking with surgeons in already the field. Don’t be discouraged. This field needs bright young surgeons to help continue its legacy. With the right attitude and a creative approach, YOU have a bright future in craniofacial surgery and the ASMS is here to help you.
Panel Discussion:  (continued from page 7)

Jeff:  So, even the thickness of the muscle, you would take the top layer of the muscle off?
Greg:  Yep. Now we are doing that.
Arun:  Are you doing this even in the children under the age 12?
Greg:  We are. In some cases, we are getting very very small muscles, even to the point where there are 10 grams or 8 grams or even 6 grams in very small kids. Yes.
Jeff:  What are you using for your anastomosis? Are you still an anastamosing to the facial vessels?
Greg:  Yeah.
Mike:  I have really tried over the last 5 years to move towards the superficial temporal vessels so I can limit the axis incision to the preauricular region and temporal hairline. I think it is favorable from a cosmetic standpoint to avoid the submandibular incision if it's possible.
Greg:  I generally prefer the facials because they are bigger recipient vessels, but it is great to hear you say that because you know, I have often wondered about doing exactly what you say you have just done.
Mike:  I find that if you trace the superficial temporal vessels into the parotid gland, then they actually can get quite sizeable. The only difference in the technique is that you have to do the nerve anastomosis first because otherwise it is very hard to try to flip the muscle over and do the nerve repair once the vessels are hooked up.
Jeff:  I think Klebuc is doing some sort of magic!
Mike:  I don't think so. I think you all can do that.
Jeff:  Hey gentlemen! I really appreciate everybody participating in the conversation tonight and I appreciate everybody allowing us to push it back a little bit. That worked out really well and I think this will do very well for the ASMS newsletter. Thanks again to all of you! I think that our membership will really enjoy it.

The first part of this discussion appeared in the Winter issue of *Maxillofacial News*. Please visit www.maxface.org to review part one of this discussion.
The following ASMS Slate of Candidates was proposed by the 2013 ASMS Nominating Committee, chaired by Robert Havlik, MD. An email will be sent to all Active and Senior Members informing them of the ASMS slate of nominees electronic balloting process, website information and voting instructions.

President
WARREN SCHUBERT, MD
St. Paul, Minnesota

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: President-Elect
Past ASMS Board Positions: Assistant Treasurer, Member-At-Large
Current ASMS Committee Work: Course Organizer for 16 ASMS Courses; ASMS Education Committee; ASMS Scientific Program Committee (Chair); ASMS Web Page Committee; ASMS Finance Committee, ASMS Maxillofacial News Committee
Other/Past Committee Work: ASMS Constitution and Bylaws Committee; ASMS Ethics Committee (Chair); ASMS Finance Committee; CME Committee; Scientific Program Committee; Program Committee; Plastic Surgery Work Force Task Force; Academics Task Force.
Medical Degree: University of North Dakota; Family Practice Residency: University of Texas, San Antonio; General Surgery Residency: McGill University; Plastic Surgery Residency: Case Western Reserve University; Maxillofacial Trauma Fellowship: Atlanta.
Years in Practice: 22
ABPS Certification: 1993

Immediate Past President
HENRY VASCONEZ, MD
Lexington, Kentucky

Academic Position/Title: Chief, Professor of Surgery, Division of Plastic Surgery; Professor, Surgery and Pediatrics; Associate 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: President
Past ASMS Board Position: Treasurer, Assistant Treasurer, Assistant Secretary
Current ASMS Committee Work: ASMS Educational Grants Committee, ASMS Finance Committee; ASMS Maxillofacial News Committee, ASMS Scientific Program Committee
Other/Past Committee Work: ASMS Scientific Program Committee (Chair); ASMS Membership Committee (Chair); ASMS Outcomes Committee (Chair); ASMS Auditing Committee; ASMS Education Committee; ASMS Maxillofacial News Committee
Academic Position/Title: Chief, Division of Craniofacial Surgery, University of Virginia School of Medicine
Current ASMS Board Position: 1st Vice President
Past ASMS Board Position: Assistant Treasurer, Assistant Secretary, Member-At-Large
Current ASMS Committee Work: ASMS Scientific Program Committee; ASMS Development Committee; ASMS Auditing Committee; ASMS Finance Committee
Other/Past Committee Work: ASMS Finance Committee (Chair); 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; ASMS Education 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 Craniofacial Surgery: Hospital for Sick Children, University of Toronto
Years in Practice: 21
ABPS Certification: 1994

First Vice President
ARUN GOSAIN, MD
Chicago, Illinois

Academic Position/Title: Professor and Chief of Plastic Surgery, Lurie Children’s Hospital, Division of Plastic Surgery, Feinberg School of Medicine of Northwestern University
Current ASMS Board Position: VP of Administrative Duties
Past ASMS Board Position: Historian, Treasurer, Parliamentarian
Current ASMS Committee Work: ASMS Visiting Professor (2011-2012), ASMS Maxillofacial News Committee (Chair); ASMS Education Committee, ASMS Educational Grants Committee; ASMS Finance Committee
Other/Past Committee Work: ASMS Auditing Committee (Chair); ASMS Educational Grants Committee (Co-Chair); ASMS Scientific Program 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; Patient Care Parameters Committee; Council of Plastic Surgery Organizations; Finance & Investment Committee; Computer-Based Education Committee
Medical Degree: UCLA School of Medicine
Years in Practice: 21
ABPS Certification: 1994
Treasurer

WILLIAM HOFFMAN, MD
San Francisco, California

Academic Position/Title: Professor and Chief, Plastic Surgery, University of California -San Francisco
Current ASMS Board Position: Treasurer

Past ASMS Board Position: Member-at-Large, Secretary
Current ASMS Committee Work: ASMS Best Paper Award Committee; ASMS Education Committee; ASMS Finance Committee; ASMS Scientific Program Committee; ASMS Task Force on Socioeconomic Issues/Reimbursements (Chair)
Other/ Past Committee Work: ASMS Best Paper Award (Chair); ASMS Educational Grants Committee; ASMS Maxillofacial News Committee; ASMS Task Force on Socioeconomic Issues; ASPS Nomination Committee; Computer Based Education Committee; ASPS/PSEF Young Plastic Surgeons Forum; Scientific Program Committee; PSEF Symposium 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 (Craniomaxillofacial/Head and Neck); Curriculum Development Committee
Medical Degree: University of Rochester
Years in Practice: 27
ABPS Certification: 1987

Assistant Treasurer

DONALD MACKAY, MD
Hershey, Pennsylvania

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: Assistant Treasurer
Past ASMS Board Position: Vice President of Administrative Duties
Current ASMS Committee Work: ASMS Education Committee; ASMS Finance Committee (Chair); ASMS Scientific Program Committee; ASMS Task Force on 2nd Edition of the Fundamentals of Maxillofacial Surgery; ASMS Task Force Socioeconomic Issues/Reimbursements
Other/Past Committee Work: ASMS Education Committee (Chair); Instructional Course Committee; Program Committee; Curriculum Development Committee; 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: 26
ABPS Certification: 1997, Re-certification 2006

VP of Administrative Duties

DELORA MOUNT, MD
Madison, Wisconsin

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: Historian
Past ASMS Board Position: Parliamentarian
Current ASMS Committee Work: ASMS Education Committee; ASMS Membership Committee; ASMS Visiting Professor Committee (Chair); Other/Past Committee Work: ASMS Constitution & Bylaws 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; PSEF Volunteers in Plastic Surgery Steering Committee; Program Committee (Research/Technology Subcommittee)
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: 12
ABPS Certification: 2002

Secretary

PETER J. TAUB, MD
New York, New York

Academic Position/Title: Professor, Surgery and Pediatrics, Mount Sinai Kravis Children’s Hospital; Co-Director, Mount Sinai Cleft and Craniofacial Center
Current ASMS Board Position: Secretary
Current ASMS Committee Work: ASMS Education Committee (Chair); ASMS Membership Committee; ASMS Scientific Program Committee; ASMS Task Force on 2nd Edition of the Fundamentals of Maxillofacial Surgery; ASMS Web Page Committee
Other/Past Committee Work: ASMS Best Paper Award Committee; ASMS Finance Committee; ASMS Membership Committee (Chair); Public Education Committee; In-Service Examination Committee; Program Committee; Finance & Investment Committee Young Plastic Surgeons Steering Committee; Curriculum Development Committee; Program Committee (Craniomaxillofacial/Head and Neck Subcommittee)
Medical Degree: Albert Einstein College of Medicine, 1993
Years in Practice: 12
ABPS Certification: 2003 (ABS Certification: 2001)

Assistant Secretary

JOSEPH LOSEE, MD
Pittsburgh, Pennsylvania

Academic Position/Title: Professor and Executive Vice Chair, Department of Plastic Surgery, University of Pittsburgh School of Medicine; Chief, Division of Pediatric Plastic Surgery, Children’s Hospital of Pittsburgh
Current ASMS Board Position: Assistant Secretary
Past ASMS Board Position: VP- Communications, Member-At-Large
Current Committee Work: ASMS Education Committee; ASMS Scientific Program Committee; ASMS Visiting Professor Committee; ASMS Task Force on 2nd Edition of the Fundamentals of Maxillofacial Surgery
Other/Past Committee Work: ASMS Visiting Professor (2011-2012); ASMS Finance Committee; ASMS Visiting Professor Committee (Chair); ASMS Task Force on Socioeconomic Issues; Strategic Education Council; In-Service Examination 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; PSEF Nominating Committee; Program Committee; Publications Committee; CME Committee; ASPS/PSEF Young Plastic Surgeons Forum; Undergraduate Education Committee; Resident Information Committee; International Scholar Committee; President, American Council of Academic Plastic Surgeons
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: 13
ABPS Certification: 2001
The ASMS wishes to solicit postings for job openings for maxillofacial surgeons. As a service to individuals who are completing craniofacial fellowships or plastic surgery residencies, we plan to post open academic positions for craniomaxillofacial surgeons at no charge. We feel that this service is justified in keeping with the ASMS philosophy of enhancing the education and practice of maxillofacial surgery. This would enable individuals who are completing craniofacial fellowships to use the ASMS Newsletter as the primary source for academic job opportunities, since we will actively solicit all such positions from academic institutions.

We will also post any non-academic positions of interest for craniomaxillofacial surgeons at the fee structure outlined below:

- Job postings for craniomaxillofacial positions at institutions with plastic surgery residency or craniofacial surgery fellowship training programs - to be solicited by the Newsletter so as to insure a complete list and posted at no charge.
- Job postings for craniomaxillofacial positions not affiliated with a plastic surgery residency or craniofacial surgery fellowship will be posted at a fee of $150 for ASMS members and $250 for non-members of the ASMS.

Please contact Lorraine O’Grady (logrady@prri.com) with any positions for craniomaxillofacial surgeons.
Lurie Children’s Hospital of Northwestern University Feinberg School of Medicine, Chicago, Illinois

Craniofacial Surgery Fellowship

Lurie Children’s Hospital will initiate a Fellowship in Craniofacial Surgery to begin July 1, 2014. This is a comprehensive fellowship, offering exposure to a full spectrum of craniofacial surgery. Specific craniofacial exposure includes: cleft lip/palate care, alveolar bone grafting, orthognathic surgery, craniofacial distraction osteogenesis, craniosynostosis, craniofacial syndromes, Le Fort procedures, monobloc advancement, facial trauma, and secondary traumatic deformities. The fellow will also have the opportunity to participate in pediatric plastic surgery involving microtia reconstruction, the multidisciplinary care of vascular anomalies, and tissue expansion. Research opportunities available in clinical and basic science with a dedicated laboratory in craniofacial biology. Please contact by email at rgrady@luriechildrens.org. All interested residents who will have completed an accredited Plastic Surgery Residency are welcome to apply for this exciting training opportunity in Craniofacial Surgery.

The University of Michigan
Ann Arbor, Michigan
Craniofacial Fellowship

The Craniofacial Fellowship at The University of Michigan offers an ACGME accredited comprehensive training program with a large clinical volume of reconstructive procedures for congenital anomalies including syndromic and non-syndromic craniosynostoses, branchial arch disorders, clefting abnormalities, orthognathic maladies as well as trauma reconstruction. Craniofacial Fellows will become facile with a broad exposure of craniofacial procedures such as frontal orbital advancement, cranial vault reshaping, distraction osteogenesis, Le Fort I, II and III osteotomy, sagittal split osteotomies, genioplasty, and other osteotomies of the mandible as well as Monoblock procedures. The Fellowship will also include a significant exposure to cleft lip and palate procedures, pediatric plastic surgery, and challenging traumatic facial reconstruction within a level 1 trauma system. The Fellow will have access to a plethora of clinical and basic scientific research opportunities including access to a state of the art NIH funded bone laboratory. The setting for this fellowship is a brand new state of the art 1,000,000 square feet Children’s Hospital. The Pediatric Plastic Surgery suite and the Fellows office are immediately adjacent to the operating rooms. The Craniofacial Fellow will enjoy the same benefits and contract advantages of the House Officers Association. Interested residents are encouraged to contact Steven R. Buchman, MD at sbuchman@umich.edu for further details. Please visit our Craniofacial Fellowship training program website at http://surgery.med.umich.edu/plastic/education/craniofacial.shtml

University of Michigan, Section of Plastic Surgery, Faculty Opportunity in Pediatric Plastic Surgery

The Section of Plastic Surgery at the University of Michigan is seeking a BC/BE plastic surgeon with fellowship training in pediatric/craniofacial plastic surgery to join our exceptional full-time academic faculty. This position presents an outstanding opportunity to join a busy clinical practice in a superb teaching and research environment. This individual will join two existing pediatric/craniofacial surgeons in the brand-new, 1,000,000 sq. ft. Mott Children’s Hospital, which will open its doors November 2011. She/he will be included in the faculty of the ACGME-accredited integrated plastic surgery residency and craniofacial fellowship programs and should therefore have excellent clinical and teaching skills. Clinical responsibilities of the position include facial trauma call, care of patients with clefts and other congenital craniofacial anomalies, vascular anomalies/laser procedures, and general pediatric plastic surgery. Academic/scholarly productivity is also expected. Contact: Qualified candidates should send a letter of interest and CV to Steven R. Buchman, MD, via email: sbuchman@umich.edu.

The University of North Carolina - Chapel Hill, Assistant Professor

The University of North Carolina at Chapel Hill is pleased to announce the hiring of a tenured faculty position at the level of Assistant Professor who will primarily care for children with a broad range of craniofacial anomalies, including cleft lip/palate, microtia, craniosynostosis, facial paralysis, facial lesions, and congenital hand anomalies. The candidate should have completed a plastic surgery residency and be board certified or pending board certification. Fellowship training in either Craniofacial Surgery or Pediatric Plastic Surgery is required. Anticipated start date is July 2013. The University of North Carolina is an Equal Opportunity Employer. Contact: John A. van Aalst: john_vanaalst@med.unc.edu

Johns Hopkins University School of Medicine / Johns Hopkins Hospital, Baltimore, Maryland, Craniofacial Surgeon-Scientist

The Johns Hopkins School of Medicine, Department of Plastic and Reconstructive Surgery, is seeking a Craniofacial Surgeon-Scientist to join our full-time academic faculty. Minimum qualifications include fellowship training in craniofacial surgery, ABPS board certification/eligibility with a strong interest in patient care, teaching and research. Candidates with experience in all areas of pediatric plastic/craniofacial surgery and prior accomplishment in basic science or clinical research are encouraged to apply. Contact: Qualified candidates may electronically submit CV and cover letter to: Richard Redett, M.D., rredett@jhmi.edu

University of California, Irvine
PGY IV Plastic Surgery Resident

The Aesthetic and Plastic Surgery Institute at The University of California, Irvine has been approved for an increase in their resident numbers by the ACGME. Consequently, we are looking to hire an additional resident into the PGY IV position. Candidates must have completed General Surgery, Otolaryngology, Orthopedic Surgery, Urology or Neurosurgery to be eligible for this position. Candidates would complete a 3 year training program in Plastic Surgery and be eligible to sit for their boards by ABPS. Interested candidates should send CV, 3 letters of recommendation, ABPSITE or In-Service Examination Scores, USMLEs and a statement of interest: Daniel Jaffurs, MD, djaffurs@uci.edu
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<td>Registration/Continental Breakfast</td>
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<td>Q &amp; A</td>
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<td>BREAK/EXHIBITS</td>
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<td>9:30 am</td>
<td>Mandibular Aesthetic Surgery: Angle Reduction</td>
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<td>11:45 am-12:30 pm</td>
<td>LUNCH/EXHIBITS</td>
</tr>
<tr>
<td>12:30 pm</td>
<td>Mandibular Distraction: Neonates</td>
</tr>
<tr>
<td>1:00 pm</td>
<td>Mandibular Distraction: Pediatric</td>
</tr>
<tr>
<td>1:30 pm</td>
<td>Mandible Osteoradionecrosis: Treatment Strategies</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Q &amp; A</td>
</tr>
<tr>
<td>2:15 pm-2:30 pm</td>
<td>BREAK/EXHIBITS</td>
</tr>
<tr>
<td>2:30 pm</td>
<td>Peri-Oral Reanimation</td>
</tr>
<tr>
<td>3:00 pm</td>
<td>Lip Reconstruction following Cancer Resection</td>
</tr>
<tr>
<td>3:30 pm</td>
<td>Lip/Perioral Rejuvenation: Combination Therapies</td>
</tr>
<tr>
<td>4:00 pm</td>
<td>Aesthetic Management of the Jaw Line</td>
</tr>
<tr>
<td>4:30 pm</td>
<td>Q &amp; A</td>
</tr>
<tr>
<td>5:00 pm</td>
<td>Adjourn</td>
</tr>
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