Despite advances in reconstructive surgery, some facial defects cannot be managed with autologous tissue transfers. This may be due to the location or size of the defect, the quality and quantity of the tissue in the area, the patient's health, or the patient's desire not to have extensive reconstructive surgery. In such cases, a facial prosthesis may be used as an acceptable alternative. This is a custom-made medical grade silicone rubber replacement for a missing or deformed ear, orbit, or nose. For many years, prosthesis was retained with skin adhesive. Currently, they are more reliably retained with osseointegrated titanium craniofacial implants.

Presurgical planning by a team of surgical and prosthetic specialists is critical to success. Three-dimensional computer imaging of the defect allows members of the team to evaluate the quality and quantity of bone in relation to the most ideal shape of the planned prosthesis. A computer-generated surgical guide based on this planning is used during surgery to locate the ideal implant locations. The surgery is performed on an outpatient basis. The bone is exposed, the implant sites are drilled with specially designed burs, and the implants are threaded into place. Following a period of healing that ranges from three to six months, the prosthesis is ready to be fabricated. It is sculpted in wax on a plaster mold of the patient's face and then tried on the patient for final adjustments of fit and shape. Ear prostheses are most often retained with metal clips to a gold bar that are connected to the implants. Nasal and orbital prostheses most commonly rely upon magnetic retention.

The same osseointegrated implants that are used to retain a facial prosthesis may also be used to retain a bone anchored hearing processor (BAHA). This is a small bone conducting hearing aid that attaches to an implant placed in the mastoid bone. These are more comfortable and less noticeable than conventional bone conduction hearing aids used for sensorineural hearing loss and provide a higher level of hearing for patients.

Both implant retained facial prostheses and the BAHA are recognized procedures by Medicare and CMS and are reimbursable by most insurance carriers. Applicable CPT codes include:

- 21208 Osteoplasty, facial bones; augmentation
  (autograft, allograft, or prosthetic implant)
- 21085 Oral Surgical Splint
- 21086 Auricular Prosthesis
- 21087 Nasal Prosthesis
- 21077 Orbital Prosthesis
- 69714 Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

### PRESIDENT’S MESSAGE

by Andrew Wexler, MD, MA, FACS

Today was a good day for me, the Boston fan in a foreign land. The Celtics finished off the pesky Atlanta Hawks to advance to their next round of the playoffs and the Red Sox won against Tampa keeping them securely in first place for the moment. That little Super Bowl problem with the Patriots is almost forgotten as the perfusions of new flowers explodes in spring gardens. My other favorite team, ASMS, is also having an extraordinary season. As the current manager of ASMS I am blessed with a sage coaching staff of Past Presidents Sadove, Evans, Thaller, Lewis, and Salyer who never hesitate to email me their advice and continue to actively contribute to our organization. In the heart of my line-up I have our heavy hitters Dr. “Knuckles” Kelly, Dr. “Screwball” Schubert, Dr. “Hard ball” Havlik and Dr. Mimis “the Greek” Cohen. In addition we have outstanding rookies Drs. Pravin Patel, Joe Losee, and Don Mackay (recently brought up from the South African League) who are making major contributions to our team. Rounding out the order we have, Drs. Vasconez, Hoffman, Gosain, and Mount. Finally, above it all I hear our chief cheerleader Dr. Steve Buchanan urging us forward while haranguing the other teams.

So, here we are in the middle of the season and here is the current box score.

- Dr. Seth Thaller has a hit with the Hyperguide. Multiple sections are already online complete with MOC practice questions. More units are coming online every month with contributors spread across our society. The wealth of expertise we have within our members is truly impressive (see page 7).

- The Basic course was a home run at Stanford in January thanks to the efforts of Drs. Peter Lorenz and Sabine Girod our local hosts, as well as the always fanatical oversight of Dr. Warren Schubert. Warren is constantly expanding the faculty base and by doing so bringing more programs into the resident mix. The addition of a cleft refresher course at the end of the basic course has also been a great success, a bonus for the residents, and an asset for older surgeons who wish to brush up on their cleft craft before volunteering for international missions. I expect another winner when Warren brings the team to Chicago in late August (page 7).

A special note of thanks to Dr. Pravin Patel for his constant innovations and efforts for the course. Vic Lewis and Pravin will be our hosts in Chicago and I encourage all program directors to send their residents as I am looking for a sell out crowd.

- President-Elect Dr. Kevin Kelly, with the aid of Dr. Bob Havlik and others is preparing us for the future by making sure we are up to speed when the government reviews the Relative Value Scale for Maxillofacial codes. This is a highly complex project, which plays out over several years and is essential for improving the reimbursement schedules for our members.

- The Educational committee under the Chairmanship of Dr. Don Mackay is larger and more productive then it has ever been in the past. Aside from the planning of new courses the entire committee has been involved in writing an extensive collection of maxillofacial questions for the MOC examination. This is tedious and exacting work and I thank all our members who have been involved in this project.

- Our collection of All Stars has been on the road for our Visiting Professors program. This program has been a huge success in not only educating residents in maxillofacial surgery but also planting our ASMS pennant in programs throughout the country. Our organization is filled with a multitude of world class reconstructive surgeons and this program helps showcase the talents of our membership. I applaud the efforts of Dr. Joe Losee in directing the success of this new diamond in our schedule (see page 8).

- Increasing our visibility and branding is a multi year project that requires the efforts of all members; the use of our logo in lectures and communications, and the wearing of our ties and pins is an essential part of that. Additionally, we are going forward with copywriting our logo and name and improving our website for both our members and the public.

Continued on page 6
Plastic surgery training will undergo one of its most significant changes over the next five years. The Plastic Surgery Residency Review Committee (PSRC) is mandated to undertake a review of the plastic surgery training program requirements (PRs) every five years, and has recently completed its first major review in thirteen years. This included: a) detailed review and analysis of the individual educational components necessary for plastic surgery training in the United States; b) delineation of the curriculum and technical skills necessary in each of these educational components; c) the continued revision that has led to the current PRs in Canada and England; d) review of training program requirements changes made in general surgery; and e) review of training program requirements changes proposed in thoracic surgery, vascular surgery, neurosurgery, and other fields.

Plastic surgery has undergone a steady and significant expansion both in knowledge base and in the technical skills required to practice current, contemporary plastic surgery in all of its major facets. In the area of craniofacial/surgical plastic, surgical solutions for fractures have developed into routine components of care, and distraction osteogenesis has developed into a major technique. Certainly, the use of bilateral mandibular osteotomies and distraction osteogenesis in the neonate is more complex and technically demanding than the alternative of lip-tongue adhesion. This increase in knowledge base and essential skills is seen in breast reconstruction (immediate/expanded autologous, DIEP flap), in aesthetics (botox/fillers/differential facelift techniques), in trunk and head and neck reconstructions (microsurgery/implantation of techniques and refinement in flap and free tissue transfers), in hand surgery (open reduction and plate fixation of radial and carpal fractures versus closed techniques), and in the rapid development and refinement of post-bariatric surgery techniques. These represent only a few of the broad changes that have taken place in our specialty and reflect the impact of continual innovation and refinement in plastic surgery. The plastic surgeon’s training and education today must have competence in all of these areas.

The Program Requirements for General Surgery have recently been changed as a result of their thorough 5-year review. Like plastic surgery, they have determined that more time is necessary for optimal training of their general surgery residents. They have altered their program training requirements by increasing the amount of time spent in ‘core’ general surgery training from 36 months to 42 months (60 months in general surgery training). This change has resulted in decreased training in many areas felt to be beneficial for plastic surgery, such as orthopedics and otolaryngology.

Finally, the PSRC considered the changes in preparatory training that have occurred as a result of the 80-hour work week. These three factors—expansion in knowledge base and increased in require technical skills, changes in general surgery training programs, and the 80-hour work week—were central issues in the decision to recommend that plastic surgery training be lengthened. It is noteworthy that the Institute of Medicine is currently considering proposals for a limited resident training to 56 hours per week, although this was not a factor in the PSRC’s recommendations.

The PS program requirements changes establish that the length of plastic surgery training in independent programs will be minimum of four years. Currently, there are 40-two-year programs and nineteen-three-year programs. The length of training in ‘integrated’ training programs will be established as six years. Currently, only four of the integrated programs are five years, and these programs will need to change to the four-year format. The PSRC also strongly suggests that plastic surgery training include experience in anesthesia, dermatology, ophthalmology, otorhinolaryngology, and maxillofacial surgery. These experiences are not required, but are encouraged, and can be obtained during the preliminary years of training. In addition, the PSRC has recommended that administering a plastic surgery training program is more complex than in the past, and has required the program director to provide support for both the Program Director and the Program Coordinator.

The PSRC went through a thorough process of engaging the plastic surgery community in the decision making phase. The proposed changes in Program Requirements were initially presented to the Association of Academic Chairs of Plastic Surgery (AACP) in Ceur-Aalten in May 2007. A web site was provided for comments. The AACP, the American Board of Plastic Surgery (ABPS), and the PSRC held a joint meeting as a Committee on Resident Education (CORE) at the C10APs in Chicago in July 2007. The revised PRs were presented at an ‘open forum’ session to the ACPs in Baltimore in October 2007. The PSRC met in Chicago in March 2008, and made several changes to the PRs based on the input from the National Resident Medical Community. The PSRC then took the PRs to the ‘closed forum’ in Baltimore in April 2008, and the PSRC met after the open forum to discuss the various changes, their justification, and their potential implications. The PRs were then presented to ACPs in April 2008, as well.

These Plastic Surgery Training Program Requirements changes were presented by the PSRC to the Council on Requirements of the ACS in June 6, 2008, and were subsequently approved by the ACS Board of Directors on June 9, 2008. In order to provide appropriate ramp up time for programs to train to the changes, they will become effective on July 1, 2009, and apply to all residents who begin plastic surgery training programs in 2011, with the first class of ‘independent program’ graduates finishing in 2014, and the first class of ‘integrated program’ graduates finishing in 2017. The PSRC must now predict the future. It has the obligation and the mandate to establish training program requirements for residents that will first be completing training up to ten years in the future. Therefore, such a large expansion in the scope and breadth of plastic surgery has significant implications for the training of future plastic surgeons. Plastic Surgery must now assume a greater share of the responsibility for adequately preparing for trainees for the future. The Plastic Surgery Training Program Requirements provide the foundation for the future of plastic surgery education.

**Tissue Engineered Solutions for Complex Craniofacial Defects**

2007 ASAPS/MBF and Synthetech B.R. Grant Award

Development of an ideal scaffold for tissue engineering requires several characteristics, including fabrication with a biomaterial that interacts favorably with living tissues, (to cell toxicity or immunogenicity) must provide cell interaction, proliferation, migration, and functional activity; it needs to have a controlled shape with predictable mechanical structure, and biodegradability; the scaffold must have a porosity allowing diffusion of nutrients into and out of the scaffold; it should allow, and even encourage, angiogenesis and be biocompatible with a reliable method of delivery.

Non-fibrous scaffolds process most of the qualities of an ideal scaffold for tissue engineering. Non-fibrous scaffolds exhibit one micron (ranging from 10–1000 μm). Non-fibrous mimics the collagen fibrils in the extracellular matrix, thereby promoting cellular interaction, including attachment, proliferation, migration, and functionality. Multiple cell types including endothelial cells, smooth muscle cells, fibroblasts; stem cells from both embryonic, bone marrow, and umbilical cord tissue (UCS), have been shown to interact favorably with non-fibrous scaffolds, and maintain their pluripotency. Non-fibrous can be created using several techniques, the most popular of which is electrospinning; this technique uses a voltage potential across which a viscous polymer is pulsed (Figure 1).
THE REFRESHER COURSE ON CLEFT LIP AND PALATE SURGERY: A VIEW (AND REVIEW) FROM THE EXPERIENCE OF DR. WILLIAM SANDO

Dr. William Sando, MD

This course: the first to be offered at the APSNS Executive Office, was titled with two hooks for the established practitioners: “Refresher” and “Reviews.” These were appealing to those with 20+ years of experience who had enjoyed early cleft repair but a paucity of case work in the past decade, and who was also now in a period of life marked by practice-placidity and an emptying home environment that allowed us to replay all of cleft care. The 9-day course with limited epilation that it entailed, as the Smile Train course at the Baltimore APSNS Meeting last fall (despite an excellent curriculum) had left a clear impression that my “mission-sculpt” might be too full to make “the grade” in terms of standards of performance. Logistics were quite satisfactory. Central national location, proximity to O’Hare Airport, and a relatively easy drive from my Midwestern residence were favorable. Facilities were crisp, and pre-meeting contact was direct and efficient. The teaching materials, distributed at the start of the session included Dr. Parsons’ monograph on unilateral cleft surgery for mission, Dr. Patel’s bilateral cleft lip surgery article, and Minard & Schindler’s chapter from Advances in Plastic and Reconstructive Surgery. All of these were superb, as was the Smile Train 3-D DVD Surgery DVD. One could read, write, and assimilate the contents of these readings, possibly even as a mail-attachment (excluding the DVD), which might have stimulated more in-depth discussion during the course as Drs. Parsons and Patel were co-instructors. The on-site lunch was tasty. Duration of the course was matched to the goals.

Logistics aside, the course content and presentations were worthy of commentary. There was a wealth of content, each of which was delivered by experts in their specialty, included Chairman Seth R. Thaller, and co-presenters: Robert W. Pravin, Michael A. Sadowski, Pravin Patel, and Mimi N. Cohen. The format was easy to follow and the content of the presentations included: “Introduction: "Unilateral Cleft Lip;" “Residual Unilateral Cleft Lip Deformities, “Cleft Lip,” “Bilateral Cleft Lip,” and “Correction: Secondary Bilateral Cleft Lip Repair.” The introduction and statement of objectives by Dr. Thaller provided the context for the entire course. This was the third course. Dr. Thaller enumerated our deficient statistics based on a large national survey of, whom 81% had participated in mission work. No other major demographics of respondents were offered. The listing of issues was complete: procedural techniques, management of oral incompetence, cleft palate, midface hypoplasia, postural airway management, cleft palate repair, and associated findings that are encountered during the course, and the provision of written handouts of reference for attendees. Dr. Thaller balanced with personal anecdotes, and he was sparing in use of technical jargon to avoid confusion, encouraging, but pre-emptually, and sans even a whiff of elitism. It was, moreover, a presentation that was quite devoid of critical cleft care. The Cleft Refresher Course was a similar high-caliber presentation as the Smile Train course; however, there was an improved atmosphere of engagement with content, and encouragement of the attendees. An additional mission title “The Fast Step” might have been helpful to warm up any remaining cold feet in the walk toward mission work. The introductory admonitions by Dr. Thaller of “safety first” and “do those things that you would do here” must be paramount.

Dr. Parsons presented unilateral cleft. He professed with an admonition to participate in several operations before tackling the Smirn Train Virtual Surgery DVD. His perspective and tempo were those of an emeritus-style educator: patient, gentle, respectful, and precise. He presented the modifications of the classic Millard rotation-advancement procedure, studding the presentation by a sequence of complete unilateral cleft cheiloplasty in an infant and the modifications of the classic Millard rotation-advancement procedure (Dr. Sadowski also shared his experience of a child with a ‘V’ shaped deformity of the cleft lip with retraction of the midline and bilateral cleft palate.)

Dr. Thaller then spoke on cleft palate repair. It was nuts and bolts mission-oriented, but as we are all aware, cleft palate repair is not the most logical surgical repair. He reiterated his preference for the Von Langenback technique of premaxillary setback for instances of “lock-out” and cited growth atrophy (the muscle of a VRAM flap usually undergoes a greater atrophic volume loss) at the bone-soft tissue junction (Butler and Lewin, 2004). In addition, the flap often results in temporomandibular joint ankylosis and trismus. However, while tumors of the mandible rarely invade the condyle, the superior osteotomy in posterior segmental mandibulectomies often results in temporalis muscle devascularization. In these cases, adequate fixation to the subcondylar remnant is often challenging and sometimes impossible. In addition, the soft tissue flaps that are used to replace the mandible in most posterior operations, and the lipotrophic support of the joint may be disrupted, further decreasing the benefit of this technique.

Use of soft tissue free flaps alone for reconstruction of posterior mandibular defects with cleft palate repair is inferior. Therefore, for many uses the vertical rectus abdominis myocutaneous (VRAM) flap results in single flap reconstruction with adequate tissue bulk to replace the missing mandible and associated soft tissue as well, and large enough skin paddle to reach significant oral mucosal defects (Butler and Lewis, 2004). Blunting of the mental nerves mandates some foramen of Monro’s ganglion sacrifice. Other advantages include a low complication rate and reduced operative time compared to bony flaps, which are important considerations in patients with significant microstomia. mandibular hypoplasia, and with whom it may be easier to manage soft tissue reconstruction than bony reconstruction where bone and/or hardware may be exposed and infected. The drawbacks of reconstruction with soft tissue rather than bony flaps include in the formation of fibrous tissue as well as the development and anteriorization of the mandible toward the resected side. However, most patients with advanced stage facial cancers underwent postoperative radiation therapy, a relative contraindication to cosmetically improving implants and soft tissue. In addition, with aggressive postoperative dental physiotherapy for occlusion, restoration of masticatory function, and dental occlusion. It should be noted that when the condyle has been resected, bony free flap reconstruction often results in some degree of malocclusion. Attempts at condylar reconstruction of the posterior mandible are often unsuccessful.

As a technical point, we design the soft tissue free flap to be slightly larger than the defect. This overcorrection helps mitigate the effects of postoperative atrophy associated with radiotherapy. Adequate flap volume reduces mandibular drift toward the contralateral side. Common complications include, but are not limited to, donor site morbidity, vascular compromise, and flap necrosis. Suction ligation of the flap is the standard. Should the flap be hypoxic, common complications include severe soft tissue ischemia and deterioration of one of the VRAM flaps. Failure of the flap over the mental foramen results in atrophy, because the mental nerve is protected in the flap. In addition, the flap include better preservation of shape and volume due to decreased soft tissue atrophy. The presence of a VRAM flap undercuts a greater flap volume loss, a longer vascular pedicle, easier simultaneous harvest, and less donor site morbidity. Soft tissue free flaps are generally preferred over the pectoralis major musculocutaneous flap for several reasons. Anesthetic flap results due to excessive bulk in the neck and inadequate bulk in the face, as well as decreased neck mobility due to tethering by the flap pedicle. In addition, the flap includes a large amount of donor site morbidity, shorter operative times, reliable healing, and good contour and length and mouth opening outcomes with reasonable revascularization. Bony reconstruction is the option of last resort. It is the surgery of the future, with the patient’s own bone, otherwise intact, and possibly with cessation of postoperative dental prostheses.

REFERENCES


Continued from Remarks by John A. Van Asl, MD on page 3

In sum, these experiments represent the first steps in the process of generating tissue engineered solutions for the complex tissue requirements of the alveolar cleft. The advantages associated with using a single posterior maxillary bone construct, bone, periosteum and keratinocytes. Our early studies suggested that all three tissue types (bone, periosteum—including fibroblasts—and keratinocytes) are capable of robust growth on nanofibrous scaffolds. Multiple remaining issues require resolution, including the definition of the optimal polymeric scaffold for each of the tissue types. This decision will influence the rate and direction of tissue growth. To achieve the ideal tissue engineered bone, periosteum, and keratinocytes, we plan to use a novel membrane assembly model. The optimized tissue engineered constructs will be tested in a canine model.

Future solutions to complex craniofacial defects, such as the alveolar cleft, will combine tissue engineering with emerging nanotechnology applications.

REFERENCES

The ASMS offers international scholarship positions for plastic surgeons throughout the world. We are now accepting applications from plastic surgeons in developing countries to complete craniofacial and cleft surgery from renowned experts. The program is geared to help aspiring surgeons in developing countries to complete craniofacial and cleft surgery centers in regions of greatest need. Three scholars have completed their fellowships in 2007. These scholars were Syed Aliuzzaman Hussain from Chennai, India, Tahmeed Ullah from Peshawar City, Pakistan; and Ahmed A.M. Nawres from Iraq. Drs. Hussain and Ullah were funded by Biomet, and Dr. Nawres was funded by the Warren Fellowship Foundation. An additional fellow, Peter Chawmo Kim from South Korea, was also funded by Biomet and is in the process of completing his fellowship.

Syed Aliuzzaman Hussain is a cleft and craniofacial surgeon at Sri Ramachandra University in Chennai, India. Dr. Hussain spent one month each with Dr. Shailesh Malekar at the Bhandana Children’s Hospital in New Delhi; Dr. Sanjiv Singh at the Max Super Speciality Hospital in New Delhi; Dr. M. A. Khan at the Holy Family Hospital in New Delhi; and Dr. Joseph McCarthy, Medical City Dallas under Dr. Jeffrey Fearon, and the University of Southern California under Dr. John Reinisch.

Tahmeed Ullah works as an assistant professor of plastic surgery at the Hayatabad Medical Complex in Peshawar, Pakistan. Dr. Ullah visited Rainbow Babies and Children’s Hospital in Cleveland to work with Dr. Aran Gossain, the craniofacial institute in South Carolina under Dr. John Persing, the New York University Medical Center under Dr. Joseph McCarthy. Dr. Ullah concluded that he was very impressed in seeing all of the American surgeons he observed working so hard and having the ability to excel in their respective fields. He felt that the fellowship particularly helped him both in personal development as well as skills and surgical techniques related to craniofacial and cleft surgery.

Dr. Ahmed A.M. Nawres is the head of plastic and reconstructive surgery at the Hayatabad Medical Complex in Peshawar, Pakistan. Dr. Ullah visited Rainbow Babies and Children's Hospital in Cleveland to work with Dr. Aran Gossain, the craniofacial institute in South Carolina under Dr. John Persing, the New York University Medical Center under Dr. Joseph McCarthy and the Institute of Reconstructive Plastic Surgery in New York to work with Dr. Joseph McCarthy. Dr. Ullah concluded that he was very impressed in seeing all of the American surgeons he observed working so hard and having the ability to excel in their respective fields. He felt that the fellowship particularly helped him both in personal development as well as skills and surgical techniques related to craniofacial and cleft surgery.

As always the fellowship and social events for ASMS would be reason enough to attend. One should also make every effort to be part of the meeting to hear the presentations and meet new friends. In this year’s meeting we are proud to have a number of international speakers. A heart felt thanks as well to the home office of our website contributors. Your involvement is what makes our society strong. We are on the way to a championship season and we expect a full report on our current standings from our membership. The course is an opportunity for plastic surgery residents to learn maxillofacial surgical techniques. It is a unique symposium that stresses ‘hands on’ labs with an opportunity to perform dental reconstruction, construction and mounting of dental models, and the making of dental splints.

We would like to strongly encourage surgeons involved in academic programs to send their residents to the ASMS Basic Course. This course is designed not only to provide a unique educational opportunity for residents, but to increase their awareness of the importance of craniofacial surgery in developing countries. We are currently exchanging proposals with regard to the workshops and believe that there is a need for these in the United States. These workshops are offered at no charge to ASPS and ASMS members and plastic surgery residents.

The course will be held:
• August 24th in Chicago, IL at Northwestern University
• January 26-27 in Miami, FL at the University of Miami
• September 2009 in Philadelphia, PA at the University of Pennsylvania

REGISTER BY PHONE AT 800-766-4955 or 847-228-9900, ext. 471.

THE SMILE TRAIN ALONG WITH THE ASPS/PSF AND ASMS WILL AGAIN OFFER NO-COST REFRESHER CLEFT TRAINING

These half-day workshops are aimed at providing plastic surgeons with refresher course training in cleft surgery. The Cleft Refresher Course is intended to meet the needs of plastic surgeons interested in participating in a surgical trip to developing countries.

Thanks to a generous restricted educational grant from The Smile Train, the workshops are offered at no charge to ASPS and ASMS members and plastic surgery residents.

The course will be held:
• August 24th, 2008 in Denver at the ANSCC Annual Meeting

Please log on to the Hyperguide website at: http://www.plasticsurgeryhyperguide.com, if you are in need of an access code, you can obtain one from the registration page of the website.

PLASTIC SURGERY HYPERGUIDE
by Monis Cohen, MD, FACS

The Hyperguide is a free, password-protected website sponsored by Vindico Medical Education, supported by an unrestricted educational grant from Strafor, and endorsed by the ASMS. The site provides a unique, user-friendly opportunity for surgeons to earn CME credits. It features topic areas called modules, which include Craniofacial Trauma and Congenital: Cleft/Craniofacial. Each module contains tutorials, which are narratives describing clinical topics. Test questions, surgical video, and lectures will be incorporated as the site progresses.
## ASMS UPCOMING MEETINGS AND EVENTS

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<th>Date</th>
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<tr>
<td>August 22-24, 2008</td>
<td><strong>ASMS Basic Maxillofacial Principles and Techniques</strong></td>
<td>Northwestern University</td>
<td>Local Host: Victor Lewis, MD and Pravin Patel, MD</td>
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<td>Feinberg School of Medicine</td>
<td>CME: 19.75 Category 1 Credits Available</td>
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<td>August 24, 2008</td>
<td><strong>Refresher Course on Cleft Lip and Palate Surgery</strong></td>
<td>Northwestern University</td>
<td>Sponsor: Smile Train</td>
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<td>October 31, 2008</td>
<td><strong>ASPS/ASMS Pre-Conference Symposium</strong></td>
<td>Functional and Aesthetic Reconstruction of the Craniofacial Skeleton Symposium Chicago, IL</td>
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<td>Co-chair: Mimis Cohen, MD and Pravin Patel, MD</td>
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<td>CME: 8.5 Credits, 1 Patient Safety</td>
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<td>October 31-November 4, 2008</td>
<td><strong>ASPS/PSEF &amp; ASMS Annual Meeting</strong></td>
<td>The ‘New’ McCormick Place West Chicago, IL</td>
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<td>February 20-22, 2009</td>
<td><strong>ASMS Basic Maxillofacial Principles and Techniques</strong></td>
<td>Miami University, The Miller School of Medicine Miami, FL</td>
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<td>Local Host: Seth Thaller, MD</td>
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<td>February 2009</td>
<td><strong>Refresher Course on Cleft Lip and Palate Surgery</strong></td>
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## ASMS VISITING PROFESSOR PROGRAM

*By Joseph Losee, MD*

The American Society of Maxillofacial Surgeons (ASMS) Visiting Professor program has been a tremendous success. We would like to express our sincere thanks to our 2006-2007 Visiting Professors Dr. Joseph Gruss of Seattle, WA; Dr. Henry Kawamoto of Santa Monica, CA; and Dr. John Persing of New Haven, CT who were our inaugural visiting professor that started this program. Our current Visiting Professors for the 2007-2008 academic year, Dr. Ronald Gruber of Oakland, CA; Dr. Douglas Ousterhout of San Francisco, CA; Dr. Kenneth Salyer of Dallas, TX; and Dr. S. Anthony Wolfe of Miami, FL have received great reviews from training programs they have visited.

For the 2009-2010 academic year ASMS has assembled another team of five prominent plastic surgeons to participate in the program. We are pleased to announce Dr. Steven Buchman of Ann Arbor, MI; Dr. Jeffrey Fearon of Dallas, TX; Dr. Christopher Forrest of Ontario, Canada; Dr. Glenn Jelks of New York, NY; and Dr. Frederick Menick of Tucson, AZ. It is our hope this team of doctors will enhance the educational experience of plastic surgery residents through lectures, discussion groups and patient evaluations.

The ASMS Visiting Professor program is supported by an educational grant from Stryker.