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*Courtesy of Peter Peng, MD

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The Cover Shot

This photo of a yellow-crested cockatoo in Tai Hang was taken by Dr Francis Ho. These birds, though endangered in their native habitat of Indonesia and East Timor, are somehow thriving in Hong Kong’s dense urban jungle. Just ask any Hongkonger who has been jolted awake by their morning cries.

Dr Francis HO
MBBS (HK), FRCS (ED), FCSHK, FHKAM (Surgery)
Specialist in Plastic Surgery

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To read more about The Federation of Medical Societies of Hong Kong
The current life expectancy for Hong Kong in 2024 is 85.42 years, a 0.15 % increase from 2023. The life expectancy for Hong Kong in 2023 was 85.29; a 0.16 % increase from 2022. Factors contributing to long life expectancy for Hong Kong include economic development, low infant mortality rate, good quality healthcare, positive social support, favourable geographical environment, healthy diet and exercise based lifestyle.

How can Plastic Surgery including Cosmetic Surgery & Medicine helps people to achieve their life goals at different stages of their life and to enjoy their long life?

In the First and second decades of life, some of us may present with facial scars after cleft lip Surgery, or facial moles removal or laceration repair surgery after accidental injuries. Dr Tor Chiu of Prince of Wales Hospital gives us “Updates on Scar Management” after his successful holding of the 3rd Congress of the Asian Pacific Society for Scar Medicine in November 2023 in Hong Kong.

In the Third and Fourth decades of life, man and women seek to look at their best to present to their peers especially to the opposite sex. Dr Mark Leung presents to us “Breast Augmentation”; Dr Franklin Li reviews for us “Cosmetic Nose Surgery” and Dr Anna Wong, President of Hong Kong Association of Cosmetic Surgery shares her extensive experience with us on “Current Trends of Medial Epicanthoplasty in Asians”. All these surgical procedures aim to enhance our facial appearance and improve the body shape of women.

In the Fifth and Sixth decades of life, many of us want to keep our youthful look as long as possible in order for us to continue to work as an energetic and productive member of society. Dr Walter King writes on “Toxins, Fillers, Skin Boosters, Collagen Stimulators and other Injectables” and while Dr Vincent Kwan of Hong Kong Sanatorium & Hospital writes on “What is Facelift”.

In the Seventh and Eighth decades of life, people aims to pursue a lifestyle that will give us long life and good health. Dr Or Chi-kong shares his approach to “My Youthful Living” with us.

So Plastic Surgeons are ready to help all walks of life at all stages of their long life to pursue and fulfill their life goals with enduring good and youthful looks. Hence, we all become well equipped to advance and progress in an increasingly competitive society.
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UPDATES ON SCAR MANAGEMENT

Dr CHIU Tor-wo

INTRODUCTION

Scar therapy is the inevitable result of a wound to the dermis; scarless healing is impossible in humans (except during the first two trimesters). The deeper the damage, the worse the scar (all things being equal), as elegantly demonstrated by Professor McGrouther in 2007 on ‘volunteers’\(^1\). The scar evolves through phases due to processes controlled by growth factors, cytokines, etc., until maturation which typically takes months, sometimes years.

SUMMARY OF CURRENT BEST PRACTICE/GUIDELINES

There are several excellent guidelines for the management of scars. The first was written by a panel of experts in 2002\(^2\), with an update in 2014\(^3\) and another concentrating on Asian skin in 2013\(^4\). These are largely consensus statements rather than meta-analyses of Randomised Controlled Trials (RCTs) with high levels of evidence. Several authors, namely Thomas Mustoe, Rei Ogawa, and Luc Teot, were on the faculty for our recent scar meeting (see below).

It is always said that prevention is better than cure. However, as stated earlier, scars cannot be prevented - if you need to cut the dermis, some scarring will result. What the surgeon can do is to optimise healing by adopting good surgical principles: paying attention to the Langer’s lines, respecting the tissues, avoiding tension in the skin closure and early removal of sutures. Smokers should be encouraged to stop at least four weeks before surgery; however, the effects of smoking are complex. The various components (carbon monoxide, free radicals and nicotine) have many deleterious effects on wound healing\(^7\), leading to an increase in wound infections and gross necrosis in flaps and facelifts. However, there is evidence that smokers lead to well-known long term local sequelae. Studies at the Prince of Wales Hospital have shown that steroid impregnated tapes, e.g. Eclar, are a potential alternative to injections but are not easily available in Hong Kong. Surgery alone for keloids is associated with a high risk of recurrence ( > 50 %), but the combined use of steroids/5-fluourouracil (5FU) or radiotherapy can reduce the risk to ~ 40 % and ~ 25 %, respectively. Scar cryotherapy for keloids is a reasonable alternative to steroid injections but is not commonly used despite the availability of FDA approved devices such as Cryoshape.

UPDATES ON SCAR MANAGEMENT

It seems appropriate to discuss updates on scar management by providing a report of an international meeting. The Third Congress of the Asian Pacific Society for Scar Medicine (APSSM) that we recently hosted at the Prince of Wales Hospital in November 2023. The APSSM was formed in 2017 with the first meeting in Tokyo 2019 just squeaked in before the global outbreak of COVID-19. The APSSM board is formed by scar experts around the Asia Pacific region. We were fortunate to be able to have a host of invited speakers from around the globe, including giants of scar medicine Thomas Mustoe, Luc Teot, Rei Ogawa and Angus McGrouther. It is particularly relevant to have a conference dedicated to Asian scarring as Asians have a higher incidence of problem scarring (HTS and keloids) while even the ‘normal’ scar response is characterised by prolonged erythema and pigmentation. The exact reasons for this are unclear, but theories include a more vigorous and sustained fibroblastic response. Asian skin has a thicker dermis with greater collagen density and increased melanin content/larger melanosomes.
Upon review of the excellent lectures, several major themes were apparent.

**SILICONE**

The silicone effect was discovered incidentally by Perkins in 1982 and reported by Quinn KJ in 1987. Its use in scar management has become widely accepted, though the exact mechanism(s) of action remained unclear. Inflammation (and tension) is important in the pathogenesis of problem scarring. While inflammation can be reduced by early closure of wounds, Mustoe found that increased transepithelial water loss (TEWL) continues due to the immature epithelium. The cellular dehydration provokes the production of pro-inflammatory mediators and more scarring. Silicone functions like mature stratum corneum, reducing TEWL and thus fibrosis. We did some work with the Department of Electronic Engineering at The Chinese University of Hong Kong using terahertz imaging to look at silicone skin hydration and found that the silicone effects are limited to the area covered; the silicone effect on skin hydration lasts for 20 minutes after 4 hours of use, increasing to a maximum of 80 minutes hydration after 12 hours of silicone use. Silicone is clinically most useful in the first two months after injury, with little effect on mature scars or keloids.

**TENSION RELIEF**

The effects of tension were discussed by several speakers, including Rei Ogawa. Tension is something that we, as surgeons, can control/influence up to a certain extent. Angus McGrath reported on his studies on scar mechanotransduction that found cells to be sensitive to mechanical forces - mechanical stimuli could be converted to biochemical signals that elicit specific cell responses. To reduce the deleterious effects of mechanical forces, the wound/scar should be supported for up to six months ideally. Absorbable sutures such as PDS that are commonly used in the deeper layers of closure only maintain strength for six weeks, whilst vicryl lasts for three weeks or less. Some surgeons recommend using buried permanent sutures in closing the dermal layer to provide lasting (internal) support, but it is more common to provide external support in the form of skin tapes. Various specific ‘devices’ have been marketed, including TopClosure and Embrace Scar Shield.

Professor Cecilia Li had previously demonstrated suppression of myofibroblast and keratinocyte proliferation by pressure and discussed how pressure therapy for scars in the form of massage, vacuum therapy, stretching, active exercises as well as pressure garments could be optimised. She discussed her ‘Smart Scar Care Pad’ (SSCP) which combines pressure and silicone therapy.

**EARLY TREATMENT**

Another recurrent theme was advocating for the early treatment of scars in a various ways. As a problem scar is seen to evolve, early injections of triamcinolone (40 mg/ml) are recommended, whilst many also combine steroids with 5FU (50 mg/ml), as advocated by Liu Wei, a speaker at the meeting. The efficacy of 5FU in scar management (though ‘off-label’) seems to be well established by many studies, but in our practice, the use of 5FU in the outpatient setting is limited by the need to admit patients in order to be able to prescribe it. Speakers report that combination therapy (steroid and 5FU) works well in resistant keloids. Bleomycin acts similarly to 5FU but is used much less frequently.

The early use of lasers is also advocated to treat immature scars. There is an absence of strong evidence to support how early lasers should be used, but the trend is to start as soon as healing starts at about four weeks for pulse-dye lasers (PDL), for example. The Shanghai group used PDL as soon as the day of suture removal or one week after healing of burn injuries to reduce erythema. The long-term benefits are unclear. ‘Good IPL with good cooling can be a reasonable alternative to PDL, which may not be available in every clinic.

Fractional lasers effectively remodel thick scars, even established mature burn scars. PDL and fractional laser treatment can be used in the same treatment session with many studies from Chinese investigators. Deep mode CO2 lasers such as ScarFX/deepFX seem more effective for remodelling thick scars. Fractional lasers can be combined with injectables in keloids, either sequentially (injections then lasers) or ‘simultaneously’ with fractional laser and drug delivery. Readers are referred to a 2020 Consensus paper on the use of lasers for traumatic scars. Professor Henry Chan discussed the use of fractional lasers in Post Inflammatory Hyperpigmentation (PIH).

Dermal substitutes such as Nevelia and Biodegradable Temporising Matrix (BTM) can be regarded as both prevention and secondary management. We have been using these at the Prince of Wales Hospital Burn Centre to treat full thickness burn injuries crossing joints in a two-stage strategy - the dermal substitute is placed onto debrided wounds. It gradually becomes vascularised over several weeks with the formation of a collagen matrix by wound fibroblasts. The dermal substitute is then covered by a thin partial thickness skin graft, providing a full thickness reconstruction at the ‘price’ of a split thickness donor site. The wound has a more pliable skin coverage that allows improved function and reduced problems with contractures. BTM was developed in Australia by Professor John Greenwood and is much more resistant to infection, providing more predictable results particularly in major burn injuries.

**RESEARCH**

There are many inherent difficulties with scar research, not the least of which is that scars tend to improve spontaneously, so careful study design with proper controls and appropriately long follow-up is important. There are few universally accepted objective measurements to allow monitoring of therapeutic effects; investigators usually use scar scores, including VSS and POSAS, with ultrasound and colourimeters for measurement of thickness and pigmentation, respectively. In addition, there are multiple components to scar pathogenesis, meaning that the study of single factors that seem to have effects in isolation does not necessarily translate well to the clinical scenario.
Collagen synthesis inhibitors, including TGF-β have not fulfilled early promise.

Amongst the many strategies currently being studied include the use of topical statins-repurposing old drugs makes getting approval easier. Mark Fear from Fiona Woods laboratory talked about developments in Lysyl Oxidase (LOX) research. Dr Tey from the National Skin Centre, Singapore, talked about innovations such as delivering triamcinolone through patches with dissolving microneedles made of hyaluronic acid. Other strategies included the delivery of novel therapeutics such as siRNA (small interfering) available as Renectin Antiscar patches.

The advent of portable radiation devices for keloids, such as the FDA approved SRT-100+ that can be used in clinic settings, may be an important development as often the patient would need to be referred to an institution. There are reports of the use of botulinum toxin at the time of surgery or fractional laser therapy to prevent / improve scarring, but basic protocols are not well established.

References
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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Updates on Scar Management" by Dr CHIU Tor-wo and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or answer link: https://forms.gle/MUVol1mDmLxRhxozf8 or by mail to the Federation Secretariat on or before 31 May 2024. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary. (Address: Duke of Windsor Social Service Bldg., 4/F, 15 Hennessy Rd., Wan Chai. Enquiry: 2527 8898)

Questions 1 - 10: Please answer T (true) or F (false)

1. Smoking has many deleterious effects on wound healing, leading to an increase in wound infections.
2. Hyperbaric Oxygen Therapy (HBOT) improves scarring.
3. The first line treatment of hypertrophic scars (HTS) is silicone therapy.
4. The first line treatment of keloid scars is intralesional injection of steroids.
5. Tension relief by sutures (internal support) and skin tapes (external support) for up to six months can reduce scarring.
6. There is a trend to start pulsed dye laser (PDL) treatment early at four weeks after healing to reduce erythema.
7. Fractional lasers are not effective in remodelling thick scars or establishing mature burn scars.
8. Steroid impregnated tapes are not useful in scar management.
9. Silicone functions like mature stratum corneum and reduces transepithelial water loss (TEWL), thus reducing inflammation and fibrosis.
10. Dermal substitute can be used to treat full thickness burn wounds without the need for skin grafting surgery.

ANSWER SHEET FOR MAY 2024

Please return the completed answer sheet to the Federation Secretariat on or before 31 May 2024 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Updates on Scar Management
Dr CHIU Tor-wo
BM BCh(Oxon), DM(Oxon), FRCS RCPS(Glasg), FHKAM(Surgery)
Chief of Division of Plastic Reconstructive and Aesthetic Surgery
The Chinese University of Hong Kong
Prince of Wales Hospital

Name (block letters): __________________________
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Answers to April 2024 Issue
Current and Future Treatments for Metabolic Dysfunction-associated Fatty Liver Disease
Dermatology Quiz

Dr KWAN Chi-keung
MBBS(HK), MRCP(UK), FRCP(Lond, Glasg, Edin), Dip Derm(Glasg), PDipID(HK), FHKCP, FHKAM(Medicine)
Specialist in Dermatology and Venereology

This 65-year-old Caucasian man complained of a hard growth on the vertex of his scalp for two years, and a superficial wound formed gradually. Otherwise, he was asymptomatic. There was no pain and no itch. There was no injury or any precipitating factors. Physical examination revealed a 1.0 cm hyperkeratotic scaly plaque with a superficial erosion on the vertex of the scalp. (Fig. 1)

Questions
1. What are the differential diagnoses of his skin lesion?
2. What investigation are you going to order?
3. How do you treat this patient?

(See P.37 for answers)
Toxins, Fillers, Skin Boosters, Collagen Stimulators and Other Injectables

Dr Walter Wing-keung KING
FRCS(Ed), FRCS(C), FHKAM(Surgery)
Specialist in Plastic Surgery
Honorary Clinical Professor, Department of Surgery CUHK

What are injectables for facial skin rejuvenation? Today, the four main categories of injectables for skin renewal are toxins, skin boosters, fillers and collagen stimulators. These are considered medical devices manufactured by the pharmaceutical industry for periodic administration by trained medical practitioners to rejuvenate sun damaged or ageing skin with the goal of restoring or maintaining a youthful look in men and women in their third decades of life or beyond.

TOXINS

Botulinum A toxin is a neurotoxin extracted from clostridium botulinum. By temporarily relaxing selected facial expression muscles, the judicious injection of a small amount of toxin in strategic points of the upper face is very effective in smoothing out dynamic wrinkles of the forehead, the crow’s feet and the glabella. The duration of action is about four months, so periodic injections every 3 to 6 months are required for maintenance. The same toxin protein upon injection is also effective in the reduction of the hypertrophic masseter muscle, causing a wide face and in the reduction of the axilla or palmar hyperhidrosis.

SKIN BOOSTERS

In addition to the topical application of skin serums, lotions and creams to improve facial skin condition, fine needle injection of low density hyaluronic acid products directly into the skin dermis is also effective in hydrating and repairing sun damaged skin. Proven products for safe skin injection include diluted botulinum toxin, low density hyaluronic acid and natural hyaluronic acid. These injected products can improve fine lines, dry skin, oily skin and sallow skin. Specially designed gun shape injectors are commonly used for the injection of small aliquots of these products in adjustable volume and depth to restore the integrity of the skin of the face, neck, back of hands and abdomen. Commonly used hydrating hyaluronic acid products include Restylane Vital, Teosyl Redensity 1, Belotero Revive and Juviderm Volite.

FILLERS

Dermal fillers are designed to add immediate volume to specific areas of the face.

A. Hyaluronic Acid

Hyaluronic acid is present naturally in the skin. It keeps the skin supple and hydrated. Increasingly popular are hyaluronic acid fillers for injection for restoring facial volume loss, such as improving hollow temple, nasal jugal groove, nasal labial line and augmentation of nose and chin. Hyaluronic acid is derived from bacterial fermentation followed by cross-linking chemical treatment to induce stability. Hyaluronic acid fillers are colourless, soft and gel like. Most hyaluronic acid fillers contain lidocaine to ease discomfort during injection. Hyaluronic acid fillers injected into strategic points of the face can lift sagging cheeks and face. As a result, the facial contour can be refined to a more youthful V-shaped appearance. There are also low density small particle hyaluronic acids that can be used to smooth out wrinkles, especially necklines (e.g. Belotero Soft). Hyaluronic acid is gradually degraded by intrinsic tissue hyaluronidase enzyme over 6 to 12 months.

Commonly used FDA approved fillers include:

i) Restylane products: Restylane, Restylane Lyft.
iii) Juviderm products: Juviderm Voluma, Juviderm Vobella.
iv) Teosyl RHA products: RHA 1, RHA 2, RHA 3 and RHA 4.

B. Autologous Fat Grafting

Autologous fat grafting (AGF) is a surgical procedure that requires the collection of autologous fat (i.e. own fat) from the body by liposuction for immediate purification and injection into the face or body to restore volume loss. Since the harvested fat also contains repair cells, including stem cells, it is suggested that AGF also works as a collagen stimulator to improve skin texture and surface appearance.

COLLAGEN STIMULATORS

Biostimulators promote collagen production for overall facial rejuvenation. They may contain non-hyaluronic acid products.
A. Polylactic Acid

Polylactic acid has long been used widely in surgery as biodegradable, dissolvable stitches or sutures. When injected in fine powder form mixed in saline into subcutaneous tissue underneath the dermis, it acts as a collagen stimulator by stimulating fibroblasts to build more natural collagen. It can improve fine lines and increase tissue volume concurrently, with the clinical effect lasting up to two years. Sculptra is a FDA approved poly-L-lactic acid collagen stimulator for injection.

B. Calcium Hydroxyapatite (CaHA)

Calcium hydroxyapatite is a naturally occurring component of bone. It is suspended in a smooth gel for injection to stimulate natural collagen production. The clinical effect of smoothing out wrinkles, improving skin texture and elasticity lasts about 12 months\(^7\)\(^8\). A FDA approved CaHA filler is Radiesse.

C. Hybrid Hyaluronic Acid and Calcium Hydroxyapatite

Hong Kong is the first locality in Asia to launch HarmonyCa, a new hybrid hyaluronic acid filler and calcium hydroxyapatite collagen stimulator from Allergan designed for facial injection to restore facial volume and increase skin tightness and elasticity. Its dual sculpting effect can last for two years after 1 to 2 injections at six months apart. It is usually placed evenly in the superficial layer of the lateral cheek and jawline underneath the skin by cannula injection\(^5\).

D. Combined High - and Low - Molecular Weight Hyaluronic Acid

Recent studies have shown that combining hyaluronic acid chains of different lengths and molecular weights improves tissue repair and regeneration. Profhilo is a biocompatible product that an innovative thermal process has manufactured to yield a stable hybrid cooperative complex of high and low molecular weight hyaluronic acid suitable for facial subcutaneous injections to stimulate tissue remodelling and collagen production. Clinical data confirm skin texture, elasticity and hydration improvement with a tightening effect lasting 6 to 12 months after a series of injections\(^9\).

COMPLICATIONS OF INJECTABLES

Each product for injection is specially formulated to have certain properties and density to be injected at a particular injection depth most suitable for placement in specific areas of the face and body. The medical doctor performing the injections should be well trained and experienced in using individual products to minimise the occurrence of excessive swelling, bruises or asymmetry and infections\(^10\). The injection technique should be refined to avoid the occurrence of rare but disastrous complications of skin necrosis or visual impairment by inadvertent vascular injection\(^11\)\(^12\).

References

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INTRODUCTION

Cosmetic nose surgery is widely accepted in the Western world as reduction rhinoplasty and in the Eastern counterpart as augmentation rhinoplasty because of genetic differences in the nose appearance. Supporting the nasal skin, the nasal bone plays a major role in the appearance. Rhinoplasty mainly aims to modify this nasal bone structure. Excessive bone needs REDUCTION, whereas underdevelopment needs AUGMENTATION. Grossly crooked noses require intra-nasal correction of the nasal septum. (Fig. 1)

Aesthetic surgeons aim for the improvement of appearance. The ancient Greek remark “BEAUTY IS IN THE EYE OF THE BEHOLDER” is always true. To please the beholder, be it herself or her friends, the RHINOPLASTIC surgeons need to alter their patient’s appearance to suit their own taste. She will tell the surgeons what is “wrong” with her appearance. Be it as it may, if the “defect” is eminently treatable, the surgeons should do as much as possible according to her wish as long as it proves safe and sound. Just follow her instructions as it is always the best solution. For other patients who cannot tell what is “wrong”, a FLAT NOSE is usually the culprit. All the surgeons need is to make the diagnosis. Viewing from the side, if they can see the opposite eye, it is a flat nose. The surgeons should always bear in mind the importance of SCARLESS cosmetic operations. Hence, cosmetic surgery is done via INTRA-NASAL APPROACHES, avoiding any tell-tale scars. Only infrequently, for better operative exposure of an "OPEN RHINOPLASTY", an external trans-columellar incision is used.

REDUCTION RHINOPLASTY

A small percentage of my patients require reduction. It is done by removing excessive bone and cartilage in the DORSUM via an internal incision between the lateral nasal cartilage and the nasal alar cartilage. (Fig. 2)

CORRECTION OF GROSS NOSE DEFORMITY

Gross deformity needs nasal bone and nasal septum correction by ENT surgeons. It is beyond the present scope. Almost all cosmetic nose surgery is done skin-deep.

AUGMENTATION RHINOPLASTY

i) Aiming at an optimal outcome, it is essential to improve the appearance of the nose by augmenting a flat nose to produce a prettier profile. (Fig. 3)
For easy reading of the surface anatomy of the nose, herewith is a diagram indicating the sites to be described. Readers, please follow the midline of the face from the glabella (between eyebrows) downwards (Fig. 4):

- The radix, between the eyes, must be low and concave to prevent a Greek goddess look.
- The dorsum must be eminent, and straight without a hump.
- The supratip area must not bulge out to overshadow the nasal tip.
- The apex (nasal tip) must project to be attractive.
- The infratip lobule must be prominent.
- The columella must be well developed without any suggestion of a `hidden columella syndrome`.
- The columella-labial angle must be over 90 degrees.
- Going laterally, the nostril sill controls the shape of the respective nostril.
- The alar facial junction can be used for ala nasi reduction with an acceptable scar.

- To achieve an attractive profile, it is narrated here the desirable appearance of the nose from the frontonasal area downwards towards the nasal tip:
  - The radix, the lowest point between the eyes, is the start of the nasal bone. My preference, however, is a little augmentation towards the GOLDEN CROSS, coined by a neighbouring surgeon, must be the limit of any augmentation. This cross is located at the junction between two lines joining the eyebrow to the inner corner of the opposite eye respectively. My own preference is to augment there only to a minor degree.
  - The dorsum must be medianly situated and perfectly straight without hump. It corrects flat noses. Downwards, when it approaches the nasal tip, there should be no SUPRATIP BULGE. The skin here is much thicker, rendering a negative cut when designing a prospective implant.
  - The nasal tip is the CENTRE OF ATTENTION. It has to be full and projecting forward so much that ambient light will shine to produce a likeness of a headlamp. (Fig. 5)
  - The columnella with an infratip lobule must be fully developed to avoid a "hidden columnella" look (for under-development, a little ear cartilage graft will suffice).
  - The naso-labial angle must be over 90 degrees.
  - A large nostril is brought together through partial excision of the nostril sill.
  - Going laterally, overgrown ala nasi requires excision through the alar facial junction, a rare external incision.

- The key to augmentation is to build up the nasal bridge. An implant is needed. Injection of any liquid fillers never works cosmetically because they just do not support the nasal skin enough to produce a good profile. Solid autografts, be it ear or costal cartilage, fascia, or derma-fat, can be used satisfactorily. Even homografts or heterografts can be used, though bone autografts require too much surgery and scarring. With the advent of inert transplantable material, solid medical-grade silicone products can safely be used. It is well accepted by the Oriental nose. For unknown reasons, the Western nose does not accept it (too oily? too much seborrheic infection?). Therefore, silicone implant is not used at all in Westerners. Furthermore, the Western skin is too thick, rendering tailoring of
the implant difficult. On the other hand, for Oriental patients, a solid silicone implant carries all the advantages to create a perfectly beautiful nose easily and permanently. One additional advantage is that it is reversible if so wished. The results are followed-up for decades. They simply remain in good shape for ever. It is well protected by the body tissue, forming a pseudo-capsule automatically weeks after implantation.

iv) In passing, bizarre materials inserted like ivory, cow bone, and candle wax were used. The worst was an injection of liquid paraffin, bee wax and snake oil. The advent of industrial grade silicone oil in the 70s was no better because it always leaked to produce a flatter nose. Moreover, it migrates to remote areas of the body.

v) The choice is to use solid silicone blocks now available commercially in different hardness. The soft grade block can be carved with curve-curve surgical scissors to the desirable shape. Now, our neighbouring countries have numerous pre-moulded rough models for sale cheaply, reducing many tasks in manual carving.

Distally, the implant has a substantial NASAL TIP BULK to augment the nasal tip. In between, a small NECK is carved to prevent a SUPRATIP hump (bearing in mind the lower 1/3 nasal skin is much thicker). An optional TAIL is inserted into the columella to prevent deviation of the eventual tip. This TAIL, if made fuller, can also enhance a weak columella. If the columella-labial angle needs widening to over 90 degrees, plicating the end of the TAIL and anchoring it there with one stitch will bring a good result. (Fig. 8)

Deviation is the worst complication. To prevent it, much effort is taken to produce a permanently seated implant that is impossible to be displaced.

The finished product is autoclaved and ready to use. Fine tuning is done at operation.

**IMPLANTATION SURGERY**

The operation is done under local anaesthesia. Via an ALAR RIM INCISION on either or both sides, a subcutaneous space is undermined with a pair of small curve-curve surgical scissors (Metzenbaum 14 cm) across the columella distal to the nasal septum. There must be sufficient subcutaneous tissue to protect the eventual implant. Using a periosteal elevator, undermining is done over the nasal septum towards the radix and slightly further to the frontonasal area, making space for the implant. The space over the dorsum must be deep to reach the periosteum. It is necessary to go deeply so that the periosteum fixes the prospective implant without deviation. To ensure the central position of the tip, the TAIL of the implant is implanted into the columella. With this lock, it is impossible to displace the newly formed tip. The incision is closed with one stitch and produces no scar.

**NASAL TIP PLASTY**

The nasal tip plays a major role in attracting attention. A projecting nose tip is eye catching. Modifying a flat nose is the key to a successful cosmetic operation. Moreover, an augmented and projected tip effectively reduces the flare and/or the roundedness of the nostrils. Once done, bystanders’ heads turn for a second look as a pair of delicate and elongated nostrils are scintillating. (Fig. 9)
Nasal tip modification is done by inserting an autograft of ear cartilage or dermal-fat through an alar rim incision. Alternatively, a small crafted alloplastic cube will suffice. (Fig. 10)

Columella strengthening is desirable to improve the look. If it is not visible from a side view as intercepted by a hanging overgrown ala, it is deemed “hidden”. Such condition is eminently treatable with an insertion of a small implant of any nature through an ala rim incision. A thicker implant tail will substantiate a weak columella. The columella-labial angle can be increased by folding the tail and putting one stitch to stabilise it there. (Fig. 11)

A weak columella is augmented with a dermal-fat autograft during tip plasty. (Fig. 12)

In this case, a flared nostril can be reduced as directed by partial excision of the NOSTRIL SILL Here, the operative scar heals well without trace. (Fig. 13 & 14)

**ADJUNCTIVE SURGERY**

An overgrown ala nasi requires reduction via the ala-facial junction and a flared nostril needs partial excision of the nasal sill.
OPEN RHINOPLASTY

A neighbouring country has initiated an OPEN rhinoplasty technique. By OPEN technique with a transverse cut across the columella joining bilateral nasal rim incisions, much more exposure can be made to the nasal tip area. With mobilising, downward displacement and multiple stitching of the ala cartilages, a good tip is created downwardly situated, effectively lengthening a short nose. More often than not, that cut across the columella heals well without a trace. That country kept their technique secret for a long time. Recently, they opened their secret with a fully attended first international conference.

This OPEN technique revolutionises and simplifies rhinoplasty. However, a transverse cut across the columella is tabooed locally. For Fung Shui reason of the belief that our fate depends on a median line running from the forehead to the chin. That transverse cut on the nose will significantly ruin fortune so to speak. By and large, the locals cannot accept this incision.

CONCLUSION

Building up a flat nose surgically can create a naturally pretty face. It has to be done without a scar. A heightened flat nose is attractive. A projecting nose tip, like a headlamp, is even more attractive to any beholders.

Acknowledgement: I heartily express my immense gratitude to Dr Konrad Li, for editing the text and the photographs.
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CLINICALLY PROVEN
Current Trends of Medial Epicanthoplasty in Asians

Dr Anna Wai-man WONG
MBBS (HK), FCSHK, FHKAM (Surgery)
Specialist in Plastic Surgery
President of Hong Kong Association of Cosmetic Surgery

INTRODUCTION

Epicanthus/medial epicanthal fold is a semi-lunar fold of skin extending from the upper eyelid across the medial canthal area to the margin of the lower eyelid. In Caucasians, medial epicanthal fold is regarded as a soft tissue abnormality and commonly associated with other abnormalities, such as primary or secondary telecanthus, blepharophimosis, ptosis and certain craniofacial syndromes.

However, the medial epicanthal fold is commonly found in normal Asians. The incidence of medial epicanthal folds in Asian populations (China, Japan and Korea) reported in the literature ranges between 40 % and 90 %1 - 4. After operating on nearly a thousand patients for double eyelid blepharoplasty, I observed that the prevalence of medial epicanthal folds is about 70 - 80 % in the local Chinese population.

Double eyelid blepharoplasty is the commonest aesthetic surgery in Asians. The presence of the medial epicanthal fold imposes restrictions on the level, and the shape of a double eyelid created. The awareness of these impacts and the demand for medial epicanthoplasty have increased tremendously in the past two decades.

CLASSIFICATION OF MEDICAL EPICANTHAL FOLDS

There are several classification methods for medial epicanthal folds1, 5. Park’s classification published in 1996, is the most commonly referred method1. The medial epicanthal folds are classified into four types: type I absence of fold; type II fold extends from the upper eyelid, covering part of the lacrimal lake and then blending with the skin of the lacrimal lake; type III fold covers most of the lacrimal lake and blending with lower eyelid skin; type IV is a rarer entity where the skin fold originates from lower eyelid and extends upward to upper eyelid (Fig. 1).

I observed that the medial epicanthal folds of any pair of eyes are never symmetrical. They varied in the actual size, thickness, tightness or tethering and the inclination angle. All these features must be considered carefully during medial epicanthoplasty in order to achieve better postoperative symmetry.

In Fig. 2, both young ladies have type III medial epicanthal folds by Park’s classification; however, the medial epicanthal folds among the two of them look quite different. Also, the medial epicanthal fold on either side of the same patient is asymmetrical to each other.

Fig. 2: Both young Ladies have type III medial epicanthal folds but varied in size and inclination angle of the skin folds (Personal Collection)

MEDIAL EPICANTHOPLEASTY ENHANCE AESTHETIC RESULTS OF DOUBLE EYELID BLEPHAROPLASTY

A medial epicanthal fold, especially a type III fold, imposes restrictions on the level and shape of the double eyelid during double eyelid blepharoplasty. By incorporating medial epicanthoplasty into double eyelid blepharoplasty will enhance the overall aesthetic results. In Fig. 3 & 4, are my two patients who underwent the same operations: mini-incision double eyelid blepharoplasty and medial epicanthoplasty (using Modified Park’s Z-epicanthoplasty). In Fig. 3, the 22 years old patient had bilateral inside-type double eyelid crease of low level and type III medial epicanthal folds. An outside-type parallel double eyelid crease of prominent level was created. Her eyes appeared larger and less roundish in shape, and the medial portion of the palpebral fissure was elongated and more tapering towards the nasal side. The intercanthal distance was reduced, and her eyes looked not so far apart compared
to preoperatively. The medial epicanthoplasty scars were satisfactory and visible upon proximity only.

**Fig. 3:** A 22 years old patient, with type III medial epicanthal folds, before (a & b) and one year after mini-incision double eyelid blepharoplasty and medial epicanthoplasty (c & d) (Personal Collection)

**Fig. 4:** A 28 years old patient, with type II medial epicanthal folds, before (a & b) and six months after mini-incision double eyelid blepharoplasty and medial epicanthoplasty (c & d) (Personal Collection)

In Fig. 4, the 28 years old patient a pretty good level and visible double eyelid creases bilaterally; however, she did not like the shape of her eyes. She described each of her eyes looked like a triangle. I altered the curvature and shape of the medial palpebral portion with medial epicanthoplasty and subtly elevated her double eyelid crease level. The patient was satisfied with the changes and the scars.

In my experience, incorporating medial epicanthoplasty into the double eyelid blepharoplasty, can achieve much better aesthetic results than double eyelid blepharoplasty alone in the following groups of patients: those with small eyes, eyes in triangular or roundish shapes, medial scleral disharmony and wide intercanthal distance.

A common misconception was frequently encountered during consultation with my patients. They believed that medial epicanthoplasty must be ended up with a double eyelid of prominent or high level. If they preferred double eyelids at a natural level, then there would be no need for the operation. Here, I’d like to stress again by eliminating the medial epicanthal fold; it gives the patient freedom to choose an outside-type double eyelid crease of whatever level (natural or prominent) and type (tapering or parallel) she or he wants.

**CURRENT TRENDS OF MEDIAL EPICANTHOPLASTY**

Historically, medial epicanthoplasty in Caucasians comprised of complex design and surgical techniques, and commonly resulted in disfiguring scars. Hence, over a long period of time, surgeons were reluctant to perform this operation. However, with the emerging new trends in the surgical approach, the published operation series increased tremendously over the past two decades.

Dr Jung I Park, Dr Yeon-woong Oh and Dr Won-min Yoo are the pioneers of the modern medial epicanthoplasty. The key principles are simple design, rearranging skin flap (skin re-draping technique) and minimizing visible scars.

Dr Jung I Park, an American-Korea plastic surgeon, first described the four types of medial epicanthal folds and his Z-epicanthoplasty in 160 cases in 1996. Minimally visible scar was achieved by incorporating the incision for medial epicanthoplasty into the double eyelid blepharoplasty (Fig. 5) and a complete release of the medial epicanthal fold from the medial canthal ligament. Dr Park modified his incision and published another series of 415 cases in 2000. His third publication in 2007 includes all the essential details and tips of his surgical method.

Korean plastic surgeons: Dr Won-min Yoo and Dr Yeon-woong Oh advocated similar skin re-draping techniques, and published their series of 215 Asian patients in 2007. They incorporated the medial epicanthoplasty incision into the double eyelid blepharoplasty incision and also along the subciliary margin of the lower eyelid. Thereafter, more and more series of medial epicanthoplasty came up using either Dr Park’s method or Dr Yoo’s method or modifications of their methods.

In most literature on the modern skin re-draping medial epicanthoplasty, the findings & results were similar. Type II and III medial epicanthal folds were the most common types. Minimal scars in the majority of the patients. Patients’ satisfaction was high. There was no report of lacrimal injuries.

I have been using Dr Park’s method all along. His incision design is easy to follow & the method works well for both type II & III medial epicanthal folds.
In my experience of about three hundred medial epicanthoplasties, I had the same findings & results as in other studies. Scars were undetectable for type II & small size type III medial epicanthal folds. For larger size type III medial epicanthal folds, scars were slightly longer & visible upon proximity. However, all my patients were satisfied & none regretted the operation.

Certainly, medial epicanthoplasty is becoming more & more popular nowadays. The re-draping technique is seen being advertised as 'invisible or scarless' medial epicanthoplasty in the commercials.

UNDESIRABLE RESULTS

Despite the promising works published on the new trends of skin re-draping medial epicanthoplasty; there are also increasing reports of undesirable results14-20.

The undesirable results reported include prominent scarring, unnatural exposure of lacrimal lake, unpleasant appearance of medial canthus, and too narrowed intercanthal distance and ectropion.

Fortunately, I never encounter these undesirable results in my operated patients. I think these results are related to poor patient selection and excessive pull of the medial canthus nasally during the operation. I have never performed medial epicanthoplasty in patients with narrow intercanthal distance nor those with an unpleasant appearance of medial canthus or lacrimal lake. During the operation, I focused on eliminating the medial epicanthal fold and creating the desired level and shape of a double eyelid crease. I will not dwell on how large I can enlarge the eye nor how much I can make the eyes closer to each other.

SUMMARY

The awareness of the impact of medial epicanthal fold on the aesthetic results of double eyelid blepharoplasty in Asians and the demand for medial epicanthoplasty has increased tremendously in the past two decades.

Current trends of medial epicanthoplasty focused on skin re-draping techniques and minimising visible scars. Among the numerous published surgical methods, I found Park’s method easy to follow and works well for most types of medial epicanthal folds.

Undesirable results can be avoided with proper patient selections and cautiousness regarding excessive tension on the medial canthus.

References

Certificate Course on

Medical Ultrasound 2024
(Video Lectures)

Jointly organised by

The Federation of Medical Societies of Hong Kong
Hong Kong Society for Ultrasound in Medicine

Objectives:

To provide up-to-date knowledge on point-of-care (POC) ultrasound to diagnose common and important medical problems seen in the acute, ward, and clinic settings. Ultrasonography in general as well as in gynecology, and obstetrics will be covered. Attendees will learn more about medical ultrasound focusing on Emergency Medicine, Family Medicine and Women’s Clinic.

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Date: 22, 29 May & 5, 12, 19, 26 June 2024 (Wednesday)
Duration of session: 1.5 hours (6 sessions)
Time: 7:00 pm - 8:30 pm
Course Feature: Video lectures (with Q&A platform for participants to post the questions)
Quiz for doctors: DOCTORS are required to complete a quiz after the completion of each lecture
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Breast Augmentation

Dr Mark SC LEUNG
MBBS, MRCSEd, FHKAM, FCSHK
Specialist in Plastic Surgery
Council Member, the Hong Kong Society of Plastic, Reconstructive and Aesthetic Surgeons

INTRODUCTION

Breast augmentation with implants, fat grafting or a hybrid of both is becoming a widely accepted and popular procedure in Asia1. The most important reason for the popularity of this operation is likely the increase in self-esteem provided by breast augmentation. However, the procedure involves operating on a female organ that undergoes extensive changes over the natural progression of life. Therefore, careful planning, communication and execution of the surgery are of utmost importance to achieve the best results.

PREOPERATIVE ASSESSMENT

A complete medical history is essential. Age, smoking history, and common medical illnesses, e.g. cardiovascular or pulmonary disease, diabetes mellitus and hepatitis carrier status are important. The patient’s current prescribed and over-the-counter medications should be obtained. A history of pregnancies, including weight change and lactation duration, is asked with particular attention paid to her breast-related history. The history includes the patient’s history of breast disease and/or procedures, the family history of breast cancer, and the age at which they happened, if any. In patients with a family history of breast cancer in their first degree relative at a relatively young age, genetic testing for BRCA1 and BRCAII genotypes should be discussed2. A mammogram and/or ultrasound of both breasts should be done as a preoperative workup for the procedure. Physical examination, including the patient’s height, weight, and proportions, should be taken. The patient’s bra size and breast shape preoperatively, as well as any asymmetries, if present, should be noted with regard to breast volume, base width, nipple-areola position, and inframammary fold. Landmarks, including sternal notch, position of nipples, anterior axillary lines, and inframammary folds should be carefully marked for detailed measurements later. If present, the skin quality, postpartum atrophy, and stria should also be noted. General breasts and axillary examinations for breast lumps and lymphadenopathy should also be carried out.

AUGMENTATION WITH IMPLANTS

The surgical treatment plan should be discussed thoroughly with patients regarding specific choices unique to breast augmentation, including incision placement, implant placement, and implant type and size, aiming at offering an individualised treatment. Unrealistic expectations and requests widely exceeding the acceptance of the general population should not be entertained. This practice limits the requirements for reoperations to factors beyond the surgeon’s control (e.g., capsular contracture) and enhances patients’ satisfaction. Lastly, all the discussions should be clearly documented with proper clinical photos of the patients.

HOW DO YOU CHOOSE THE INCISION?

Common incisions in breast augmentation with implants include inframammary, periareolar, and transaxillary. (Fig.1) In the transaxillary approach, endoscopic assistance in dissection is used for better visualisation3. All the incisions listed are currently used by surgeons performing augmentation mammoplasty, and each incision has its advantages and limitations. Regardless of the incisions of choice, there is no doubt that it should be tailored to the patient’s breast characteristics and will. For example, a periareolar approach should be used for patients who want an areolar reduction or lift, while an inframammary fold incision should be chosen for patients who want to keep injury to the breast gland as little as possible. On the other hand, a very thin Asian patient without significant breast tissue, lacking a defined inframammary fold, may be at risk for increased prominence of an inframammary scar. In general, the inframammary and periareolar approaches will provide more direct and precise pocket dissection than the transaxillary approaches unless endoscopic assistance is employed. Researchers have been looking into different complication rates with respect to the incision chosen and did not give a definite causal relationship4-7.

Fig. 1: Common incisions for implant based breast augmentation. (Ref: https://www.breasts.com.hk/)
WHICH IMPLANTS TO USE?

While saline implants were once a mainstay in implant based breast augmentation due to restriction on the use of silicone gel in the U.S. from 1992 to late 2006. Currently, most of the implants in Asians are silicone implants. Since Cronin and Gerow introduced the first-generation silicone gel-filled implant in 1962 with a thick, smooth silicone shell, there is enormous research to improve both the safety and quality of silicone implants. Currently, most silicone implants are filled with fifth-generation cohesive gel with a tight control guided by the FDA.

Texturing of the silicone shell of implants was developed as an attempt to decrease the rate of capsular contracture. Evidence shows that the capsular contracture rate for textured implants in sub-glandular placement is less than the rate for smooth implants, while the rate is similar in subpectoral placement. It can be divided into microtexture vs macrotexture. Macrotextru implants provide more stability and less capsular contracture rate but have more potential for bacterial growth. Some macrotextru silicone implants have been removed from the market due to this possibility of biofilm and its relationship with breast implant-associated anaplastic large cell lymphoma (BIA-ALCL).

Anatomical implants have been advocated in Asians due to the small breast size in general and the ‘fake look’ when using round implants with unnatural upper pole fullness. Also, it provides more lower pole fullness and projection in order to better define breast shape. The downside is that it does not change in shape with the patients’ posture and often remains sturdy when patients lie down. It also carries the extra burden of precision with placement, as distortion and malposition may be apparent. With advances in technology, we could now achieve better results with ergonomic implants in which the implant shape changes according to patients’ posture. If a hybrid procedure with fat grafting is performed with a smaller implant size, better palpability and shape can sometimes be very similar to natural breasts.

Choosing the perfect size for the patients is always a challenge while it involves a lot of discussion with patients in understanding their expectations. It very much depends on the patient’s breast dimensions and tissue quality. For example, a young, thin, nulliparous lady with minimal breast tissue will make a more aggressive upsizing difficult while a multiparous lady with a history of breastfeeding will benefit from bigger implants in order to lift her breasts. The most common requests in my practice are around two bra cup size increases. More aggressive upsizing may often result in an unnatural appearance with implants alone, and I often suggest a hybrid procedure with implants and fat grafting in order to give more natural results.

WHERE TO PLACE THEE IMPLANTS?

Traditionally, implants are placed either subglandularly or subpectorally, or dual plane.(Fig.2) The patient’s breast shape and tissue characteristics are the two most important factors determining the choice. Studies have indicated that submuscular placements have a lower capsular contracture rate than subglandular placements. In addition, the subglandular position places the implant closer to the skin surface, giving better cleavage but with higher risks of palpability and rippling, as well as symmastia, particularly in patients with little breast tissue, as in many Asians. Recent research suggests that subfascial placement has the advantage of improving upper pole contour, avoiding implant edge visibility, keeping the implant in place and avoiding muscular dynamics over the implants. Dual plane is more commonly used in Asians, especially when choosing smooth implants, as the capsular contracture rate is much lower. However, implants placed at this plane may lead to the dividing and weakening of the pectoralis major muscle as well as animation deformity.

AUGMENTATION WITH FAT GRAFT

Fat transfer is another option for breast augmentation. Reasons for the recent increase in demand for this procedure are its advantages over implant-based breast augmentation, including avoidance of foreign bodies with implants and its associated complications such as capsular contracture and malposition deformity. While there were concerns about its potential complications in the past, emerging reports in the literature have proven the safety and efficacy of fat grafting to breasts because the postoperative incidence of malignancy is not increased and the limited data regarding the radiologic impact of fat grafting to breasts suggest that there is little interference with breast cancer screening.

The ideal patient for breast augmentation with fat grafting is a patient who has abundant adipose tissue as a donor site for harvesting and a pliable skin pocket and sufficient tissue dimension that serves as a good recipient base for injection of adequate volume of graft will be well indicated for breast augmentation with fat grafting. For patients expecting a more natural change of the breast size around 120 cc to 150 cc, one bra cup size increase will also be very suitable for this procedure.

After taking a detailed medical history, patients with a high risk of breast cancer should be informed that they should pay extra attention to surveillance after the procedure.
procedure. Patients who are heavy smokers should also be informed about the lower survival rate of the fat cells and advised to stop smoking before and after the procedure. After a thorough discussion and explanation of the procedure with the patients, proper clinical photos, including donor sites are taken and a consent form should be signed before the procedure.

The surgical procedure is divided into three parts: Fat graft harvesting, Fat graft processing and Fat graft injection. Fat graft harvesting can be done using different techniques. Common donor sites include the abdomen, flanks, and thighs. Higher cell concentration of lipoaspirates is reported in the lower abdomen and inner thigh in the young (21 - 37 years old) female group and they are also better donor sites for adult mesenchymal stem cells. Hence, they are often chosen as the “preferred” donor sites for fat transplantation.

The author prefers to perform breast augmentation with fat graft under general anaesthesia, although it could also be done under intravenous sedation or local anaesthesia. The tumescent solution used in general anaesthesia should keep the lidocaine concentration at its minimum at 0.01 % in Ringer’s lactate solution with an adrenaline concentration of 1:200,000. Vasoconstriction caused by adrenaline facilitates haemostasis, and also decreases the chance of fat embolism by intraarterial injection of fat graft. Fat aspirate should be done under low suction pressure or with a special machine that helps preserve the viability of harvested fat cells, e.g. water assisted liposuction. High energy assisted liposuction methods are generally avoided in order to prevent lysis of fat cells, although there are reports claiming lower energy may give similar fat graft survival rates. A 1:1 ratio of aspirated fat to the tumescent solution is carried out and is allowed to set a standstill by gravity. The watery part and oil are removed, leaving the fat part of the lipoaspirate behind. The lipoaspirate is then centrifuged at 3,000 rpm for 3 minutes, as advocated by Coleman and excess fluid and oil are discarded, leaving behind the concentrated fat for injection. (Fig.3)

Placement of fat graft to the breasts requires an understanding of the anatomy and meticulous execution to distribute them evenly. The fat graft should be injected subcutaneously, behind the breast parenchyma, into and beneath the pectoralis major muscle. The author tries not to inject into the breast parenchyma to avoid further misinterpretation of breast imaging, but it is controversial and is a surgeon’s preference. The fat graft is slowly injected with a blunt tip cannula with a fanning technique through a stabbed incision at the areola, premaxilla and inframammary fold. Surgeons should advance the cannular gently into the correct plane and inject retrograde, aiming at a small droplet of fat 0.5 ml. Care is taken not to inject repeatedly in the same area.

In that case, the survival rate of the fat is greatly enhanced and complications, e.g. oil cysts and calcified fat, is avoided. On average, every breast augment breast augmentation session with fat graft should be limited to 150 to 250 cc on each breast side. For Asian ladies with breast circumference of 80 cm at its inframammary fold, 150 to 250 cc injection would approximately be one bra cup size increase. In patients who desire more aggressive upsizing, surgeons could either repeat the procedure in six months or combine it with an implant as a hybrid procedure.

**BREAST IMPLANT-ASSOCIATED ANAPLASTIC LARGE CELL LYMPHOMA**

Breast implant associated anaplastic large cell lymphoma (BIA-ALCL) is a relatively new and uncommon entity that was only first reported in 1997. It has been treated with aggressive therapies, similar to cutaneous lymphomas, until recently when we have gained a better understanding of its characteristics and formulated its own treatment category.

The diversity of presentations warrants high alertness to all medical professionals who deal with patients having implant-based breast augmentations. Need to consider and rule out this diagnosis in patients with textured implants or a history of such devices or those who exhibit symptoms like late seroma, breast swelling, capsular contracture, or peri implant mass. And then the patient should be examined by comprehensive breast imaging, employing either ultrasound (US) or magnetic resonance imaging (MRI). A fine needle aspiration (FNA) of at least 50 cc is carried out if peri implant collection is found and sent for an assessment of cell morphology through cytology, presence of CD30 and anaplastic lymphoma kinase (ALK) expression via immunohistochemistry, and an evaluation, quantification, and characterisation of T cells and additional biomarkers through flow cytometry. Tissue biopsy should be carried out in case a solid tumour is detected on imaging.

Once BIA-ALCL is confirmed, discuss in a multidisciplinary meeting, includes oncologists, breast surgeons, breast imaging specialists, pathologists, and plastic surgeons. Positron emission tomography-computed tomography (PET-CT) scans are a useful preoperative tool for proper staging of the disease. The treatment approach involves “en bloc capsulectomy”, which is the main determining factor of the treatment response rate. Surgically excised tissue and aspirated fluid are subsequently sent for further analysis to
determine the tumour margins and pathological disease stage.

In summary, breast augmentation has evolved through the past decades and remains one of the most popular plastic surgeries. With recent advances in techniques and technologies, we should continue to strive to give our patients the safest and best outcome possible.

References
What is Facelift?

Dr Vincent Kin-hung KWAN
MBChB, FRCS(Edin), FCSHK, FHKAM(Surgery)
Specialist in Plastic Surgery

INTRODUCTION
Ageing is a natural process for all living creatures. The quest to be forever young is the dream of many people. The quest has been a battle between mankind and nature for thousands of years, with the example of Emperor Qin Shi Huang trying to seek eternal life in the past. Even with the advancements in medicine, up till now, there isn’t proof of any medication that can help people achieve eternal life, with nature being the only winner. It would require surgery to achieve facial rejuvenation. As such, a facelift is a type of operation that could potentially turn the clock back and make people look younger.

Facelift has been practised for over 100 years. Currently, it is the sixth most performed aesthetic surgery in America. Although many types of face lifts exist, only some are effective. However, it is important to note that there isn’t a single type of facelift that can meet the needs of all patients.

To better comprehend facelift surgery, it is instrumental to understand the anatomy of the human face and the history of facelift.

FACE ANATOMY
The structure of the human face consists of 5 layers of tissue. These layers are supported by retaining ligaments. The first layer is the skin. It is smooth and fine during childhood. The skin will form varied pigments, fine and coarse wrinkles during ageing. Subcutaneous fat lies under the skin. The third layer is the superficial musculoaponeurotic system (SMAS). It covers the fourth layer, which is the muscles of facial expression. The retaining ligaments extend from the deep fascia of the muscles of facial expression through the SMAS, subcutaneous fat, and then to the skin. SMAS is a tough fascia like structure. It can hold and sustain tension while being stretched. SMAS is an important structure in facelift surgery. Under the facial muscles is the 5th layer, periosteum, or deep fascia.

FACELIFT PROCEDURES
Facelift surgery involves the following steps: Skin incision, skin undermining, the tightening or shortening of SMAS, the redraping and removal of excessive skin, and finally, skin closure.

SKIN INCISION
Skin incision is designed to conceal the scar. The incision starts inside the temporal scalp, curves around the sideburn, continues in front of the ear, and loops around the ear lobe to the mastoid. The incision then curves down along the occipital scalp or along the hairline. If more skin is planned to be removed, a zig zag incision will be done at the temporal hairline to prevent the receding of the hairline.

SKIN UNDERMINING
Skin is undermined in the very superficial subcutaneous plane. The extent of the undermining depends on the method of SMAS tightening. For lower SMAS techniques, the skin flap is raised short of the nasolabial fold and marionette line. For extended SMAS techniques, the skin flap is raised 1 or 2 cm anterior to the SMAS incision. Undermining of the upper neck and chin is the same for both techniques.

TIGHTENING OR SHORTENING OF SMAS
Since the introduction of SMAS concept on facelift by Dr Sam Hamra and Dr Fritz Barton, more than ten methods of SMAS tightening have been practised up till now. They can be classified as low and extended SMAS techniques, respectively. SMAS plication, Smasectomy, and SMAS imbrication are regarded as low SMAS techniques, whilst deep plane and high SMAS can be regarded as extended SMAS techniques.
Low SMAS techniques do not require cutting of retaining ligaments or touching the facial muscle of expression. Technically, it is safer and takes a shorter time to complete the operation. For SMAS plication, loose SMAS is plicated to fixed SMAS. For SMasectomy, a segment of SMAS is excised and the cut edges of the SMAS are sutured together. For SMAS imbrication, a short SMAS flap is raised and double breasted together with sutures.

The posterior border of the platysma of the neck is raised and plicated to the mastoid fascia, which helps tighten the neck and restores the cervicofacial angle. Low SMAS technique can be indicated in patients with less facial sagging. It can improve the lower face, jowl, and marionette lines. However, the angle of mouth will lift upward and laterally if too much tension is applied to the SMAS. The Zygomatic retaining ligament and the Masseteric retaining ligament are not divided using the low SMAS technique. These two ligaments prevent the upward movement of the mid face during a facelift. For this reason, the low SMAS technique cannot improve the sagging of mid face and nasolabial fold.

High SMAS technique can be indicated in all ageing faces. It can improve the nasolabial fold, marionette line, jowl, as well as the mid face. SMAS is raised from the parotid fascia, muscles of facial expression, and buccinator muscle fascia to the mid face. Branches of the facial nerve are safeguarded. Zygomatic and Masseteric ligaments are divided. The SMAS flap will then be plicated to the zygomatic arch to conduct the deep plane technique and the temporal fascia to conduct the high SMAS technique. Again, the posterior border of the platysma of the neck is raised and plicated to the mastoid fascia using the low SMAS technique.

**SKIN REDRAPING, SKIN EXCISION, AND CLOSURE**

After the tightening of the SMAS, the skin flap can be redraped to the desirable vector, usually superiorly and posteriorly, with excessive skin excised. The wound will be closed in two layers without tension.

**POSTOPERATIVE CARE**

Postoperatively, patients should wear a face mask for 3 - 4 weeks which helps redrape the skin and decrease facial swelling. A soft diet is advised for 2 - 3 days. Frequent cold compression should be applied to decrease pain and swelling. If a drain is inserted, it can be removed after one or two days. Stitches will be removed after seven days. Patients can return to work after one or two weeks.

**COMPLICATIONS**

Overall, facelift surgery is safe, and complication rates are low. The most common complication types are minor skin slough, which accounts for around 3.6 %, and haematoma, which contributes to approximately 1.8 %. Other complications such as infection, motor and sensory nerve injury, deep vein thrombosis, pulmonary embolism, parotid fistula, and sialocele all attribute to less than 1 % (Nicholas R Sinclair et al.).

The potential risk factors for complications include high blood pressure, smoking, anticoagulation or aspirin, BMI > 25, post operative vomiting, and pain.

**HOW TO AVOID COMPLICATIONS**

Patients should conduct a complete evaluation before the operation. They need to have good blood pressure and body weight control. They must stop smoking and anticoagulation for one week.

Intraoperatively, surgeons must know the facial anatomy well and handle the tissue meticulously. Good haemostasis must be obtained. The use of perioperative board spectrum antibiotics and intermittent compression devices is important to lower the risk of infection and deep vein thrombosis.

Postoperatively, adequate analgesic and antiemetics will be provided, and patients should mobilise as soon as possible.

**LIMITATION OF FACELIFTS**

The sagging of the face is only one feature of ageing. Other features include texture and quality changes of the skin, soft tissue loss at mid face, drooping of the upper eyelid, prominent eyebags, the sagging of eyebrows, and the involution of the upper and lower lips. Facelift is good for lifting the face and neck. Facelift surgery does nothing on the forehead, and periobital and skin conditions. Auxiliary procedures such as forehead lift, upper and lower blepharoplasty, mid face lift, lipofilling, laser, and high energy machines will be required to complete the rejuvenation of the face. Total facial rejuvenation is a complicated process. It must be tailor made according to the patient’s needs, expectations, clinical conditions, availability of expertise, and available instruments. Nonetheless, it is important to note that no single procedure can fulfil the needs of all patients.

**References**

11. Chapter 6-13, Aesthetic Plastic Surgery, Sherrell J Aston; Douglas S Steinbrech, Elsevier
16. Nicholas R Sinclair, Demetrios M C. Aesthet Surg Open Forum 2021 Jan, 3(1)
In the contemporary era, individuals are experiencing prolonged lifespans, emphasising the importance of enhancing overall well-being, including better health and improved quality of life. In addition to seeking improved general health, there is a growing desire for an enhanced external appearance and a more youthful look. In plastic surgery, procedures such as facelifts, brow lifts, blepharoplasties, liposuctions, and abdominoplasties are available. However, there is a notable trend toward options with reduced downtime and complications.

Over the past few decades, various energy-based devices such as laser, radiofrequency, and ultrasound have emerged as viable alternatives. Additionally, procedures like thread lifting, botulinum toxin, and dermal fillers have gained prominence, each presenting distinct benefits and limitations.

**MY WAY TO LOOK YOUNGER**

In my personal quest for a more youthful appearance, I gravitate towards intense Pulsed Light (IPL) and Ultrapulse CO2 laser (UP). While acknowledging that these methods cannot fully address all signs of ageing, they do offer reasonable results, widespread applications, and minimal downtime and discomfort.

**INTENSE PULSED LIGHT (IPL)**

IPL operates on the principle of selective photothermolysis, effectively targeting skin melanin pigments, enhancing skin tone, and reducing redness, including conditions such as telangiectasia, cherry spots, post-acne inflammatory scarring, and rosacea. Moreover, it stimulates dermal collagen metabolism, minimising pore size and fine wrinkles while also reducing facial hair.

**ULTRAPULSE CO2 LASER (UP)**

Meanwhile, the UP laser, with a wavelength of 10,600 nm, induces tissue vaporisation by absorbing energy from tissue water molecules. This enables the removal of undesired skin tissues such as seborrheic keratosis, viral warts, seborrheic hyperplasia, or syringomas - common "impurity indurations" on the face. Furthermore, with the assistance of a fractional scanner, the UP laser can improve the appearance of facial scars, acne scars, and certain wrinkles, thereby contributing to a smoother facial skin surface.

By harnessing the capabilities of these two energy-based devices, I can help individuals achieve a smoother, brighter, and more youthful appearance.

**MY WAY TO LIVE YOUNGER**

In line with the guidance of healthcare professionals, maintaining a balanced diet, adequate rest, and...
appropriate exercise are crucial for sustaining overall bodily health.

While personally engaging in indoor gym exercises several times a week, the constraints of the COVID-19 period have prompted me to incorporate more outdoor activities, such as running and hiking.

Initially commencing with a slow 2 - 3 km run in the park daily, I gradually progressed to covering 5 - 8 km each day. Following these exercises, I noticed a considerable increase in energy levels and an improved sense of well-being.

As for running, it offers several advantages:

1. Flexibility: It can be done at any time, be it morning, lunch hour, or evening.
2. Self-regulated: Frequency and duration can be tailored to individual preferences without scheduling or partners.
3. Minimal equipment: It requires only a pair of sports shoes to begin, although more specialised gear can be acquired as interest grows.
4. Social engagement: It can be enjoyed alone or with companions, and joining running classes is an option for structured training.

To combat potential monotony, numerous scenic running tracks in Hong Kong, such as the Victoria Harbor side on both Kowloon or Island side, Tolo Harborside, and Shing Mun riverside, Castle Peak Road from Tsuen Wan to Tuen Mun.

Additionally, participating in running competitions, ranging from 10km to full marathons, provides an opportunity to immerse oneself in the vibrant running community and atmosphere.

For an enhanced running experience, I advise the following:

1. Opt for runner shorts featuring secure pouches and zip-up pockets, which are ideal for carrying essentials such as mobile phones, ID cards, and keys during your run.
2. Carry a soft, easily portable water pouch to ensure proper hydration throughout your run. This pouch can be conveniently stowed in the shorts' pouch.
3. Utilise a smartwatch or sports watch to monitor and track training progress and various health metrics.
5. Essential accessories like a cap, quick-dry T-shirt, and towel can be readily found at sports equipment stores to complement your running routine.

In conclusion, running is an accessible and effective means of staying healthy and vibrant. Additionally, a consistent skincare regimen, encompassing gentle cleansing, moisturising, and sun protection, can complement these efforts, contributing to a more youthful appearance.
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<td>Topic: Nocturia Made Easy</td>
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<td>Speaker: Dr Robert LAW</td>
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<td>Speaker: Dr TAM Yat-cheung</td>
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<td>Venue: The HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, HK</td>
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<td>Speaker: Dr Jason SO</td>
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<td>Speaker: Dr Sandy CHAN</td>
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<td>FMSHK Executive Committee Meeting</td>
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<td>Topic: Evolving oncological treatment for early breast cancer and the management of lingering treatment toxicities in survivors</td>
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<td>Organiser: The HKMA District Health Network</td>
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<td>Speaker: Dr Jessica Wing-yu LAI</td>
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<td>Venue: Greater China Club, Unit A, 10/F, D2 Place ONE, 9 Cheung Yee Street, Lai Chi Kok, Kowloon</td>
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**Remarks**

HKMA CME Dept. Tel: 3108 2507 1 CME Point

HKMA CME Dept. Tel: 3108 2514 1 CME Point

HKMA CME Dept. Tel: 3108 2507 1 CME Point

HKMA CME Dept. Tel: 3108 2514 1 CME Point

HKMA CME Dept. Tel: 3108 2507 1 CME Point
<table>
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<tr>
<th>Date / Time</th>
<th>Function</th>
<th>Enquiry / Remarks</th>
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<tbody>
<tr>
<td>27 MON 2:00 PM</td>
<td>Zoom Topic: Invasive Pneumococcal Disease is Back! Updates in Local Epidemiology of Invasive Pneumococcal Disease Organiser: The Hong Kong Medical Association Speaker: Prof Ellis Kam-lun HON</td>
<td>HKMA CME Dept. Tel: 3108 2507 1 CME Point</td>
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<tr>
<td>28 TUE 2:00 PM</td>
<td>Zoom Topic: The Current Status of RSV Vaccine: A Look at the Latest Research Organiser: The Hong Kong Medical Association and The Chinese University of Hong Kong Centre for Health Education and Health Promotion Speaker: Prof Christopher Kei-wai LAI</td>
<td>HKMA CME Dept. Tel: 3108 2507 1 CME Point</td>
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<tr>
<td>28 TUE 7:00 PM</td>
<td>Certificate Course on Cytophenomics 2024 (Video Lectures) Organiser: The Federation of Medical Societies of Hong Kong Speaker: Dr Pauline SO</td>
<td>Ms ToTo CHAN Tel: 2527 8898</td>
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<tr>
<td>29 WED 2:00 PM</td>
<td>In-person The HKMA CME Lecture for District Health Network CME Programme Topic: 1-Screening and Treatment of Chronic Kidney Disease in Type 2 Diabetes; 2-Non-steroidal MRA: clinical case and practical consideration Organiser: The HKMA District Health Network Speaker: Dr WONG Wai-sheung and Dr Ginsy Mei-wa TONG Venue: Crystal Ballroom A &amp; B, 2/F, The Cityview, 23 Waterloo Road, Kowloon, Hong Kong</td>
<td>Mr Peter HO Tel: 3108 2514 1 CME Point</td>
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<td>29 WED 7:00 PM</td>
<td>Certificate Course on Medical Ultrasound 2024 (Video Lectures) Organiser: The Federation of Medical Societies of Hong Kong Speaker: Dr TSUI Chi-leung</td>
<td>Ms ToTo CHAN Tel: 2527 8898</td>
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<td>30 THU 7:00 PM</td>
<td>Certificate Course on Difficult Communications in Healthcare 2024 (Video Lectures) Organiser: The Federation of Medical Societies of Hong Kong Speaker: Dr CHOO Kah-lin</td>
<td>Ms ToTo CHAN Tel: 2527 8898</td>
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### Upcoming Event

5 to 7 July 2024 Hong Kong Primary Care Conference 2024 - "Family Medicine in the Community: Strengthening Connections" Organiser: The Hong Kong College of Family Physicians Hong Kong Primary Care Conference 2024 - "Family Medicine in the Community: Strengthening Connections" Speaker: Please refer to https://www.hkpc.org.hk/scientific-programme Chairman: Dr Lorna NG Venue: HKAM Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong | HKMA CME Dept. Tel: 3108 2507 1 CME Point |

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# Peel 2.0 New Generation Tergated Peel Treatment

- TreatmentMinimal side effect*
- Higher and earlier therapeutic response*
- Maintained for a relatively long periods*


HK & Macau Sole Distributor: ☎️: +852 9183 7388 📧: info@dermatriz.com

NO MIRACLES, JUST SCIENCE.
Certificate Course on
Mental Health 2024
(Video Lectures)

Jointly organised by

The Federation of Medical Societies of Hong Kong
The Hong Kong College of Psychiatrists

Objectives:
This course aims to introduce to the allied health professionals and Registered / Enrolled Nurses (General) on the aetiology, course, and management of common psychiatric disorders in Hong Kong. Each topic will be delivered by a specialist psychiatrist who has extensive clinical expertise and academic knowledge in that particular area. After the course, the participants will have better understanding about the course, nature and current evidence-based treatments of various common psychiatric disorders. The course will be suitable for allied health professionals and Registered / Enrolled Nurses (General) working in mental health fields, general hospital settings, as well as social care settings in the community.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topics</th>
<th>Speakers</th>
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</table>
| 6 Jun 2024 | Anxiety and Phobias                              | Dr. Tam Fung Ling
Specialist in Psychiatry                      |
| 13 Jun 2024 | Dementia                                         | Dr. Pan Pey Chyou
Specialist in Psychiatry                      |
| 20 Jun 2024 | Insomnia and Management of Sleep Disorders       | Dr. Luk Jing Si
Specialist in Psychiatry                      |
| 27 Jun 2024 | Common Psychiatric Disorders in Children and Adolescents | Dr. Chin Pui Man, Queenie
Specialist in Psychiatry                      |
| 4 Jul 2024  | Psychosocial Approaches in Psychiatry            | Dr. Hung Chi Hong, Rommel
Specialist in Psychiatry                      |
| 11 Jul 2024 | Practical Clinical Approach for Psychosis in General Setting | Dr. Cheng Pak Wing, Calvin
Specialist in Psychiatry                      |

Date: 6, 13, 20, 27 June & 4, 11 July 2024 (Thursday)
Duration of Session: 1.5 hours (6 sessions)
Time: 7:00 pm – 8:30 pm
Course Feature: Video lectures (with Q&A platform for participants to post the questions)
Quiz for Doctors: DOCTORS are required to complete a quiz after the completion of each lecture
Language Media: Cantonese (Supplemented with English)
Course Fee: HK$1,000
Certificate: Awarded to participants with a minimum attendance of 70% (4 out of 6 sessions)
Deadline: 30 May 2024
Enquiry: The Secretariat of The Federation of Medical Societies of Hong Kong
Tel.: 2527 8898  Fax: 2865 0345  Email: toto.chan@fmshk.org

CME / CNE Accreditation in application
Online Application from website: http://www.fmshk.org
The Hong Kong Society for Paediatric Immunology Allergy and Infectious Diseases (HKSPIAID)

The Hong Kong Society for Paediatric Immunology Allergy and Infectious Diseases (HKSPIAID) is a professional organisation dedicated to promoting the health and well-being of children in Hong Kong through the advancement of knowledge and expertise in the fields of immunology, allergy, and infectious diseases. HKSPIAID is a Standing Committee Member of the Asian Society for Pediatric Infectious Diseases (ASPID) and also a Board member of the World Society for Pediatric Infectious Diseases (WSPID). Comprised of healthcare professionals, researchers, and educators, HKSPIAID serves as a platform for collaboration, education, and advocacy in paediatric immunology-related disciplines.

HKSPIAID plays a vital role in raising awareness about paediatric immunology, allergy, and infectious diseases among healthcare professionals, policymakers, and the general public. The Society provide expert advice to shape healthcare policies and community initiatives; and also participates in public health campaigns to educate parents and the public about the prevention, diagnosis, and management of these conditions, aiming to empower individuals and promote a healthier environment for children in Hong Kong.

HKSPIAID has made significant contributions to the COVID-19 pandemic response in Hong Kong. HKSPIAID has played a crucial role in educating and raising awareness within the community. Through the development and dissemination of educational resources, clinical recommendations and guidelines, the Society has ensured that healthcare professionals, patients, and the public are well-informed about COVID-19, its transmission, prevention measures, and vaccination. Additionally, HKSPIAID’s expertise in the field has contributed to valuable research efforts, including studies on the impact of the virus on paediatric populations and vaccine effectiveness. By collaborating with other healthcare organisations and advocating for the needs of children, HKSPIAID has worked tirelessly to promote vaccine uptake while addressing the unique challenges faced by paediatric patients and their families. Through the Society’s multidimensional efforts, HKSPIAID has been instrumental in mitigating the impact of COVID-19 on children and promoting the overall health and well-being of the community.

HKSPIAID aim to promote clinical practice excellence in by fostering collaboration and knowledge-sharing among healthcare professionals. The Society organises annual scientific meetings, Study Day, and medical education activities, supporting professional development and promoting scientific research and academic activities through grants and awards, fostering innovation, and improving patient outcomes.

Through its commitment to collaboration, education, research, and advocacy, HKSPIAID contributes to the advancement of knowledge, excellence in clinical practice, and the overall improvement of pediatric immunology, allergy, and infectious disease care in the region.
Answers to Dermatology Quiz

Answers:

1. Major differential diagnoses include actinic keratosis, seborrhoeic keratosis, Bowen’s disease, squamous cell carcinoma (SCC) and discoid lupus erythematosus.

Actinic keratosis is a precancerous condition commonly found in sun-exposure areas, especially on the face, bald scalp and upper chest. It is also known as solar keratosis. It is an ultra-violet (UV) light-induced lesion, and the DNA of the skin keratinocytes is damaged by short UVB. It may progress to SCC.

2. Actinic keratosis is usually diagnosed clinically by its classical characteristics. In case suspected any malignancy changes, a skin biopsy is needed. Actinic keratosis is typically presented with dysplasia in epidermis. The epidermis may have hyperkeratosis, parakeratosis and irregular acanthosis. Some nuclear atypia may also be found. However, hair follicles, sebaceous glands and other skin appendages are not involved.

3. The primary aim of treatment is to remove the actinic keratosis. Although the risk of changing to SCC is small, the patient may have multiple lesions of actinic keratosis. Cryotherapy with liquid nitrogen is one of the commonest treatments for actinic keratosis. Cauterisation and curettage may be considered for some hyperkeratotic lesions. Furthermore, an excision is carried out especially in suspected malignant cases like our patient’s. Other medical treatments such as imiquimod and 5-fluorouracil may be the options if the patients refused or contra-indicated for cryotherapy or invasive surgical treatments.

Dr KWAN Chi-keung
MBBS(HK), MRCP(UK), FRCP(Lond, Glasg, Edin), Dip Derm(Glasg), FDI(D)(HK), FHKCP, FHKAM(Medicine)
Specialist in Dermatology and Venereology

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**Dermatology Quiz**

**Answers:**

1. Major differential diagnoses include actinic keratosis, seborrhoeic keratosis, Bowen’s disease, squamous cell carcinoma (SCC) and discoid lupus erythematosus.

2. Actinic keratosis is usually diagnosed clinically by its classical characteristics. In case suspected any malignancy changes, a skin biopsy is needed. Actinic keratosis is typically presented with dysplasia in epidermis. The epidermis may have hyperkeratosis, parakeratosis and irregular acanthosis. Some nuclear atypia may also be found. However, hair follicles, sebaceous glands and other skin appendages are not involved.

3. The primary aim of treatment is to remove the actinic keratosis. Although the risk of changing to SCC is small, the patient may have multiple lesions of actinic keratosis. Cryotherapy with liquid nitrogen is one of the commonest treatments for actinic keratosis. Cauterisation and curettage may be considered for some hyperkeratotic lesions. Furthermore, an excision is carried out especially in suspected malignant cases like our patient’s. Other medical treatments such as imiquimod and 5-fluorouracil may be the options if the patients refused or contra-indicated for cryotherapy or invasive surgical treatments.

Dr KWAN Chi-keung
MBBS(HK), MRCP(UK), FRCP(Lond, Glasg, Edin), Dip Derm(Glasg), FDI(D)(HK), FHKCP, FHKAM(Medicine)
Specialist in Dermatology and Venereology
DISCOLORATION DEFENSE
HIGH-POTENCY TREATMENT TO DISRUPT THE SOURCE OF HYPERPIGMENTATION, INCLUDING MELASMA

60% AVERAGE IMPROVEMENT IN THE APPEARANCE OF STUBBORN BROWN PATCHES*

SAFE AND EFFECTIVE WHEN COMBINED WITH LASER TREATMENT FOR MELASMA

IN AS EARLY AS TWO WEEKS
BRIGHTENS | EVENS | FADES

AVERAGE results in the appearance of melasma

3% TRANEXAMIC ACID (TXA)
KOJIC ACID
NIACINAMIDE
HEPES

Contact for enquiries: 2828 1383

*Average results. Clinical grading in basal, S, norma and S hyperpigmentation. Efficiency and reliability evaluations were conducted at intervals and at weeks 4, 8, 12 and 16. Number of test subjects for each group: 46. Therapy: A, B, C, D, 8-week, single session, 4-week study was conducted on 75 hyperpigmentation. All patients A, B, and D were treated with a single session, B, and C patients were treated for 2 weeks. Therapy D and E were treated with a single session, 8-week, single session, 4-week study was conducted on 75 hyperpigmentation. All patients A, B, C, and D were treated with a single session, B, and C patients were treated for 2 weeks.