Neurotoxin Treatment: It Ain't What It Used to Be

For those of us who have been around cosmetic dermatology long enough to remember the introduction of neurotoxins, we can better appreciate the comings and goings of aesthetic trends concerning *neuromodulators* (the now politically correct term).

When Botox was first introduced, this strange "pretty poison" arrived like a comet out of nowhere. Not often do practitioners get the opportunity to experience a true paradigm shift, but the introduction of neurotoxins represented one.

During the last decade of the last century, people expected treatments with neurotoxins to result in facial paralysis. If a patient presented to the clinic for neurotoxin injection and could garner a single twitch the following week, they would call back to complain. In fact, it was very obvious to discern who was and who was not receiving neurotoxin injections. It was an easy assessment to make because often people that were receiving injections often looked like stroke victims. This became problematic for actors and media types because facial animation is an integral part of communication.

I have been personally administering neurotoxin injections since 1996 and over the past several years (but especially over the past year) have noticed a significant shift away from what patients want and what doctors do. Physicians who frequently administer neurotoxin injections in their practices have long realized that paralysis generally is not a positive aesthetic attribute. Having said that, most patients function very well without glabellar movement but not moving the rest of the face looks pretty unnatural. Seasoned practitioners understand this and the neurotoxin treatments they administer usually reflect this. Novice neurotoxin injectors who have learned how to inject neurotoxins from textbooks and photographs are more prone to have cookie-cutter (and often unnatural) results with neuromodulators.

The phenomenon of neuromodulator customization has long been brewing between experienced injectors and experienced patients. I continue to see an increase in the number of patients who have been receiving Botox injections for years, and now when they present for their injections, they want to dictate the treatment pattern and sequence. I hear some colleagues complain about *patient-directed treatment* because they resent being "told what to do," but I actually welcome the input because these patients usually know what they want and what works best for them. Frank Sinatra sang, "I did it my way," but many successful neurotoxin injectors understand that patient input can be the key to a truly happy patient. "I did it our way" may be a more appropriate slogan for astute practitioners and patients.

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I personally have seen a dramatic increase in patient-directed treatment and I believe it is the result of a perfect storm of several factors. The foremost factor is the plain and simple fact that many of these patients have been receiving regular neurotoxin injections for over a decade and they know what works, what they like, and what they dislike. Fueling this fire of patient-directed treatment is our tremendously sour economy that has pretty much changed the rules and prevented or limited frivolous expenses for many patients. Trying to economize a bit has led some patients to try to get more with less, or at least the same with less. A patient who has been coming in for years for treatment with 25 units to the glabella and 25 units to the frontalis may request a dose of 15 units to each area and find out that the difference is minimal and the savings are great. Sometimes the results and longevity are quite similar and other times they are not, but the cost savings may trump the difference. This made me realize that for a long time we

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probably were overtreating some of our patients, at least in relative terms of their being satisfied with less result.

I have paid close attention to my own use of neuromodulators and for the first decade of my experience the most popular treatment regions were glabella, frontalis, and lateral canthus, in that order. Over the past 3 years, I have observed a shift in this lineup and the lateral canthal region has displaced the frontalis as the second most commonly requested region. I think the reason for this is the fact that many patients may feel overtreated with concomitant glabellar and frontalis treatment. Also, patients with low hairlines or short foreheads can experience a good bit of frontalis deactivation as a result of glabellar treatment.

In any event, I believe it is safe to say that the savvy cosmetic consumer desires a more natural appearance and looking frozen is "so last century."

When I first began treating patients with injectable neurotoxins, I kept an accurate record on each chart of each injection site and individual injection dose. After a number of years, I got away from this convention and simply recorded "20 units to glabella," etc. Over the past 4 to 5 years, I have gotten back into the habit of more accurate record-keeping, which is always a good thing. My prime motivation was not so much to express accuracy, it was more a factor of my becoming more artistic with my injections and my patients becoming more savvy about what they wanted. This combination of doctor and patient appreciation of accuracy, precision, and effect warranted close attention to how much I injected and precisely where I placed the injection because little things can make a big difference, especially in the eye of the beholder. Also germane is the fact that when we hit on a winning combination of units and location, the patient returned saying, "Please do exactly what you did last time; it was the best treatment I ever had." It is really for this reason that the physician administering the injection requires an accurate road map of where they were and how to get there again. In my practice, our charts have a drawing of the head and neck from multiple views (not a big deal as most practitioners have this, or similar decals) and we record the number of units over the treated area. When the patient returns and is happy or unhappy with the previous treatment, we know where to go or not go. This entire paragraph sounds pretty elementary for practitioners experienced in injecting neurotoxins, but is very important for novice "needlers."

As many of you who are reading this editorial make part of your income through a small-gauge needle, we all could add or challenge my statements, but one thing is for sure, we all invest more thought in customizing the neuromodulator treatment experience now than we did when we first started. Like with many other treatments, we often begin by seeing the forest and we see the trees as we refine. I guess this is why neuromodulators and filler treatments are so darn fun for most of us. It is the melding of science with the art of our individualism that makes most of us smile when we are told, "Doc, we have a patient for treatment with filler and neurotoxin in room 3." We once again get to do our thing.

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