Most Defects Don't Justify Permanent Filler Use

BY DOUG BRUNK
San Diego Bureau

LAS VEGAS — In Dr. David M. Duffy's opinion, the perfect cosmetic filler doesn't exist and probably never will.

Current fillers on the market "are really a trade-off between results that don't last long enough and complications that last forever," he said. "In my view, the ideal filler would last 2-3 years, enough to give patients their money's worth, but not long enough to give them the problems that may occur."

Dr. Duffy, who practices dermatology in Torrance, Calif., discussed the contraindications and benefits of permanent fillers at the annual meeting of the American Society of Cosmetic Dermatology and Aesthetic Surgery.

Patients demand permanent fillers for superficial defects from time to time without understanding that "there may be lots of serious, unreported complications with permanent fillers, particularly silicone, which has been used (pure or adulterated) in over 1 million patients," he said. "In fact, for every complication we see published, there are probably 10 that we've never heard about."

Key reasons to avoid permanent fillers in most patients, he said, are that temporary and semipermanent fillers are more profitable and less demanding to use, and more forgiving. "If you make mistakes with permanent fillers, they're for good; there's no margin for error," he noted.

Permanent fillers also require more time to inject, which makes them an unattractive option for hurried patients who want a true "lunchtime" procedure.

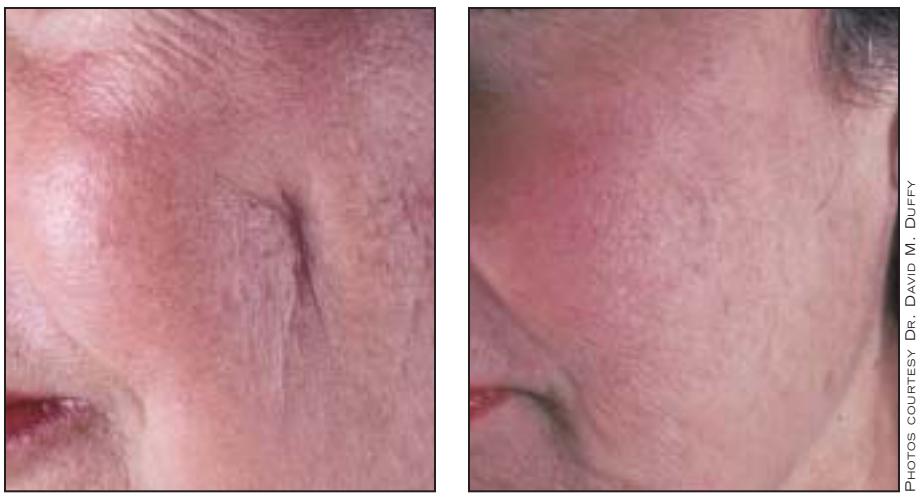
"You shouldn't use permanent filler before you get to know your patient," Dr. Duffy advised. "Temporary fillers give you an idea of how they're going to comply and respond."

Then there's the need for thorough training to properly place the filler. "Patient selection is quite demanding and there is a narrower range of appropriate defects than you have for the temporary fillers," he said.

"Be careful of the psychologically unstable patient who's had permanent filler placed by another practitioner and wants more," Dr. Duffy warned. "I won't treat patients who have had silicone placed previously. Problems can be delayed for 20 years, and you'll be blamed if they occur. I won't use permanent filler in polyallergic patients, and I won't make lips the size of Cleveland, no matter what they ask for."

Permanent fillers can be used appropriately in defects that are pliable enough so that when elevated the surrounding tissue is unaffected. They should not be used in areas where the skin is thin and hyperdistensible. Superficial defects "are very easy to overcorrect with permanent fillers, and if you do, it's there for good," Dr. Duffy said. "You can have delayed excessive fibrosis, particularly in high motion areas like the lips. And the implant may become visible as patients age."

Despite his misgivings about permanent fillers, Dr. Duffy currently uses liquid silicone in some cases. The product he uses most often is 1000 centistoke liquid silicone (Silikon 1000), which has 10 times the viscosity of water. "It's appealing because it's permanent, inexpensive, and wonderful to use," Dr. Duffy said.



PHOTOS COURTESY DR. DAVID M. DUFFY

Despite Dr. David M. Duffy's misgivings about permanent fillers, he uses liquid silicone in some cases, such as in the patient above (shown before and after).

For patients with atrophy related to HIV, he prefers 5000 centistoke liquid silicone (AdatoSil 5000), which has 50 times the viscosity of water.

The liquid silicone fillers don't have to be refrigerated, they will not support bacterial growth, and patients don't require allergy testing prior to use, said Dr. Duffy. "Most of the problems that I've see with silicone have occurred with infectious processes, particularly in patients with dental problems or sinus problems."

The most serious problems occur following misuse of silicone in "back room" operations. These include ulceration, cellulitis, granulomas, fistulation, blindness, and death.

"There are people who have made a lifestyle of criticizing silicone, because they see nothing but complications" and would never use them, he said. "Meanwhile, I've received some wonderful letters from patients who've received liquid silicone. I think there is a place for these products."

The conundrum about liquid silicone is the lack of objective data supporting its use and the lack of standardized product in years past, Dr. Duffy said. "Everything's anecdotal, with the exception of one unpublished study. This makes it difficult. Can you use these safely? Yes, you can. But you have to pick your patients well and know what you're doing. In the proper patient, silicone has no equal; good results are the norm and patients are enormously satisfied. Conversely, silicone's reputation makes it risky to use and the risk is particularly prominent for the physician, not the patient."

Dr. Duffy had no relevant conflicts of interest to disclose. ■

Avoiding Dermal Filler Pitfalls Begins With a Mirror

BY DOUG BRUNK
San Diego Bureau

LAS VEGAS — As part of her pretreatment consultation before providing dermal fillers, Dr. Ranella Hirsch hands a mirror to her patients and instructs them to advise her on their specific goals and expectations.

"I can't tell you how many times I have looked at the patient on a consult, assessed precisely what I thought the ideal aesthetic outcome is, and then be told that it's actually something completely different that they are here for me to treat," Dr. Hirsch said at the annual meeting of the American Society of Cosmetic Dermatology and Aesthetic Surgery. "A mirror is your friend."

She went on to discuss other ways to avoid potential pitfalls:

► **Always snap before and after photographs.** "There are limited legal protections," said Dr. Hirsch, a dermatologist who practices in Cambridge, Mass. "Before-and-after photographs are one of the few things that will objectively capture accurate data."

► **Beware of unrealistic expectations.** "You need to know what unrealistic expectations are and not treat those people in the first place," she said. "You're not going to make them happy and you're going to make yourself miserable in the process."

► **Assess for medical contraindications.** These include history of hypersensitivity or allergy to known filler ingredients, history of oral herpes simplex virus and keloids, and any problems with scarring. "In my office, we check for these problems three times," said Dr. Hirsch, who is the immediate past president of the ASCDAS. "And it is remarkable how many people neglect to mention these critical points until being asked repeatedly."

► **Make sure patients can afford the services required for the outcome desired.** Be wary of patients who require three syringes of product for optimal results yet only want to pay for one.

► **Have patients fill out a consent form during every visit.** Nothing is more important to the aesthetic physician than informed consent, she emphasized. "I am surprised every time I hear a physician say, 'I use the consent form that came with the job.' Should complications arise, it is critical that this has been done properly to protect yourself."

Describing her own consent forms, she noted, "It's not enough that patients sign at the very bottom of removed pages of small print. They have to sign next to each potential complication and initial it. It has to be witnessed by someone and time stamped. These are critical aspects." She advised checking with an attorney for the best relevant advice.

► **Educate patients about common side effects.** To help reduce the occurrence of purpura, Dr. Hirsch advises patients to eat a lot of pineapple preprocedure, because it contains bromelain. Another option is to take five tablets of arnica, a substance commonly used for muscle pain and bruising, the night before the procedure and another five on the day of the procedure.

Other ways to minimize bruising include applying pressure during and immediately following the injections, using topical anesthesia, mixing the filler with collagen products to stabilize platelets, adding a lidocaine wash to injectables that do not contain an anticoagulant, and using the "push ahead" technique, whereby you get the needle tip to the plane and extrude the needle ahead of the tip. By using this technique, which Dr. Hirsch attributes to Dr. Jean Carruthers, one allows the product rather than the sharp edge of the needle to create the injection plane for the product, thereby reducing tissue trauma (Dermatol. Surg. 2005;31:1604-12).

Should evidence of infection develop after the procedure, incise and drain the abscess as rapidly as possible. Culture the patient for both routine and atypical bacteria and prescribe a course of empiric antibiotics followed by specific antibiotics. "Follow up on those cultures," Dr. Hirsch advised.

If blanching or pain occurs at the injection site, stop immediately, because this can be the only sign of an impending vascular injury. Immediate administration of heat, massage, and nitroglycerin paste helps minimize or reverse permanent injury. A recent case report demonstrated that immediate administration of hyaluronidase can also be of great value (J. Drugs Dermatol. 2007;6:325-8). Once the vascular accident is managed, consider treatment with a pulsed-dye laser or intense pulsed light to improve discoloration.

Dr. Hirsch had no conflicts to disclose relevant to her presentation. ■