

MedEsthetics®

The Guide for Excellence in Medical Aesthetics

Allured business media

November/December 2026
Volume 22, Number 8
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The Art of The Soft Surgical Touch

MedEsthetics Explores Minimally Invasive Procedures

- Ethics in Wellness
- Your Next Facelift and AI
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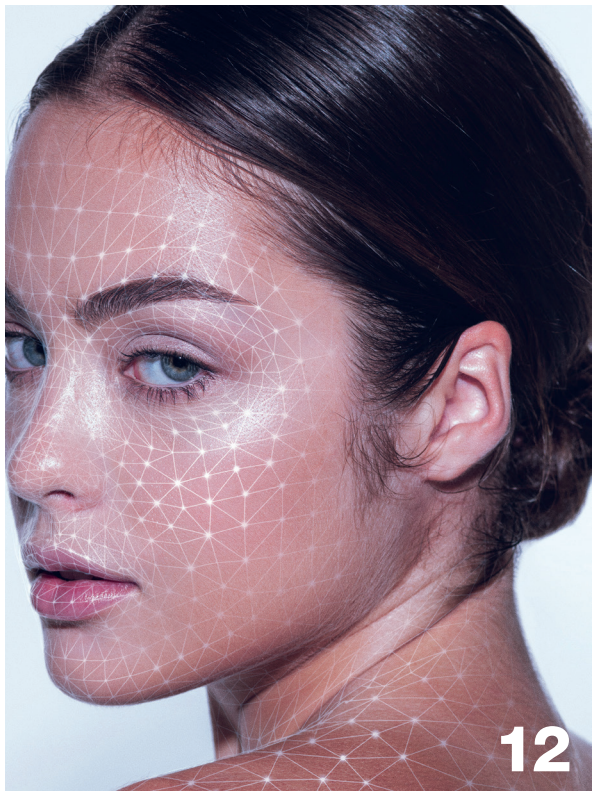





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A Lighter Touch: The Rise of Minimally Invasive Aesthetic Treatments



The shift toward minimally invasive aesthetic treatments is reshaping how practices approach facial rejuvenation.

No one likes their face touched. Well, I know I don't. I don't care if it's my 8-year-old daughter, my 4-year-old nephew, or my 95-year-old grandmother reaching out to pinch my midface volume. There's something sacred about the regions from the periorbital area down to the décolletage that feels, in a way, defiled by foreign hands.

Well, apparently, aesthetic medicine patients feel the same: Aesthetic medicine market studies report a massive rise in minimally invasive, nonsurgical options such as botulinum toxin injections, dermal fillers, and laser treatments, as ongoing improvements in device technology and injectable products have increased their safety, effectiveness, and, effectively, appeal.

To me, that's no surprise. The less touch on God's masterpiece (my face), the better.

The November/December issue of MedEsthetics looks at the industry's pivot to minimally invasive procedures, from natural-looking blepharoplasty outcomes and rethinking approaches to lower-eyelid and neck rejuvenation to busting myths about the nonsurgical butt lift.

This issue also dives into aesthetics ethics and how professionals should handle the over-informed patient.

Learn how different practices are fine-tuning their approach to the growing less-is-more attitude around aesthetic procedures. And remember: no matter the circumstance, preferably with sunscreen on daily, protect your face!

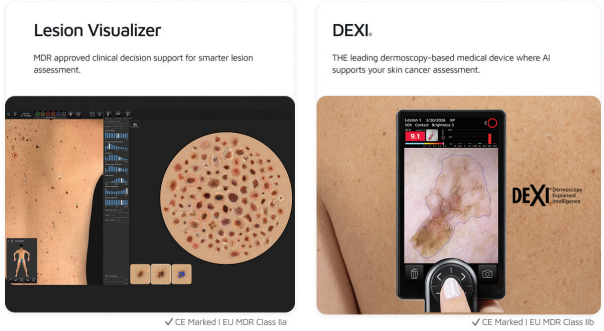
Signing off,

Image by Rabizo Anatolii at Adobe Stock



On September 11, 2026, **Galderma launched its ALASTIN skincare brand** at Korea's GAIN RESTAGE event in Seoul. Themed "Injectable Renaissance," the launch featured treatment approaches involving Restylane and Sculptra, covering fillers, biostimulators, and skincare used around aesthetic procedures. The speakers demonstrated procedures using Restylane Eyelight, Restylane Kysse and Restylane Lyft. They also discussed combination approaches using the biostimulator Sculptra together with Restylane fillers.

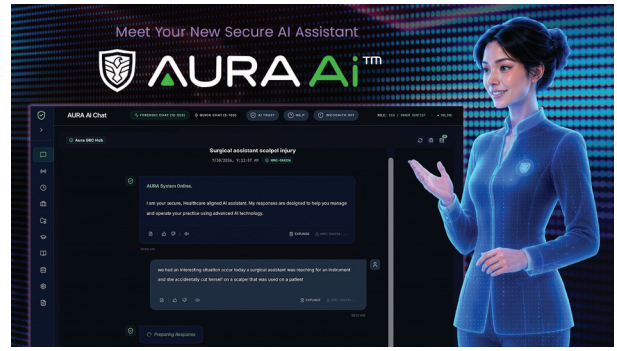
Galderma's Korean launch of ALASTIN puts peri-procedural skincare alongside injectables, reflecting a broader shift toward integrated treatment protocols before and after aesthetic procedures. The GAIN RESTAGE event also offered a look at how Korean physicians are approaching Restylane and Sculptra, including combination strategies, periocular treatments, facial contouring and NASHA-based injection techniques.



On September 30, 2026, **Canfield Scientific Inc.**, a leading provider of imaging systems and products for medical and skin care, announced that its AI decision-support tools, **Dermoscopy Explained Intelligence (DEXI®) and Lesion Visualizer**, received CE marking under Regulation (EU) 2017/745 (EU MDR).

Intended for trained clinicians experienced in skin cancer diagnosis, the tools support standardized assessment of suspicious lesions. DEXI* is a Class IIb device supporting clinical decision-making for skin cancer assessment, while Lesion Visualizer** is a Class IIa device supporting lesion change detection.

As AI moves deeper into dermatologic assessment, regulatory clearance is becoming important for practices evaluating these technologies. Canfield's EU MDR CE Marks mark a step in AI-assisted lesion assessment, spanning evaluation, clinical decision support and lesion tracking.



On September 25, 2026, **Black Talon Security announced the launch of AURA Ai™**, a secure, healthcare-focused AI companion and personal assistant designed to provide doctors, dentists, and administrators with secure, knowledgeable support.

The platform was designed to address the challenges healthcare professionals face as they navigate HIPAA, OSHA, human resources, cybersecurity, contracts, insurance requirements, office policies, clinical preferences, and constantly changing best practices. AURA helps reduce that burden by combining healthcare-focused knowledge with the organization's approved documents, policies, procedures, and protocols.

"Doctors and practice administrators are asked to be experts in almost every aspect of running a healthcare organization, and that is no longer realistic," said Gary Salman, CEO and co-founder of Black Talon Security. "Even the most experienced leaders cannot know every answer."



According to the latest **American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS)** annual member survey, patients are increasingly prioritizing subtle, natural-looking results—and nowhere is that shift more apparent than around the eyes.

According to the survey, **Blepharoplasty** remains one of the top three facial plastic surgeries, alongside rhinoplasty and facelifts, while 66% of AAFPRS members report a rising trend in eyelid procedures to help patients look less tired.

For aesthetic physicians, the evolution of blepharoplasty underscores the importance of evaluating the brow, eyelids, orbital fat, tear trough, cheek and midface as interconnected structures. The shift toward tissue preservation and repositioning also offers a useful framework for understanding why today's "rested" result can require a more nuanced approach than traditional blepharoplasty.

Courtesy of the manufacturers

BUSINESS CONSULT BY DR DUCU BOTOACA



The Non-Surgical Butt Lift

Why Shape, Not Size, Should Be the Goal

The conversation around buttock enhancement has changed considerably over the past decade. What was once largely associated with surgical Brazilian Butt Lifts and significant volume enhancement has evolved into a much broader discussion about contour, proportion, symmetry and how to achieve results that look appropriate for the individual patient.

This is where I believe non-surgical buttock enhancement has an important role to play.

However, I would argue that we need to change the way we think about the "non-surgical butt lift". The objective should not simply be to create a bigger buttock. It should be to create a better-balanced silhouette, while also considering the patient's lifestyle and how much disruption they are prepared to accept as part of their treatment.

Bigger does not necessarily mean better

Patients rarely arrive with exactly the same anatomy or exactly the same objective. Some want more projection. Others are concerned about a lack of definition, asymmetry, changes following weight loss or irregularities following

Image courtesy of the author

previous procedures. Some simply want a subtle change that makes their proportions feel more harmonious.

Treating all of these concerns by adding volume indiscriminately is not good aesthetic medicine.

The buttocks are three-dimensional structures, and treatment needs to take into account the relationship between the buttocks, hips, waist, thighs and lower back. A result that looks impressive in isolation may not necessarily look natural when considered in relation to the rest of the body.

This is why I believe the future of non-surgical buttock enhancement is less about chasing volume and more about **precision**.

Non-surgical does not mean non-medical

There is also an important misconception surrounding the term "non-surgical". Because a procedure does not involve an operation, it can sometimes be perceived as inherently simple or risk-free. It is neither.

Injectable buttock enhancement is still a medical procedure. It requires a proper understanding of anatomy, appropriate patient selection, sterile technique, product knowledge and the ability to recognise and manage complications.

Patients should be assessed individually before treatment. Medical history, previous procedures, skin and tissue quality, anatomy and the patient's expectations all matter. Not everyone is an appropriate candidate, and sometimes the safest clinical decision is not to treat.

This is particularly important as demand for these procedures grows and more providers enter the market. The popularity of a treatment should never be allowed to replace proper clinical judgement.

A more personalized approach

One of the biggest developments in aesthetic medicine has been the move away from standardised treatment towards personalised treatment plans.

We already see this in facial aesthetics. A good practitioner does not inject every patient's lips, cheeks or jaw in exactly the same way. They assess the individual face and determine what will create balance.

The same principle should apply to the body.

When I developed the DBL™ (Ducu Butt Lift), my intention was to approach buttock enhancement from this perspective. DBL™ is an injectable buttock contouring technique using dermal filler, with treatment planned according to the patient's anatomy, goals and clinical suitability.

The aim is not to impose one particular shape on every patient. It is to understand what is already there and determine where carefully considered enhancement may improve proportion, contour or symmetry.

For one patient, that might mean focusing on projection. For another, it may be about addressing a particular contour or asymmetry. In some cases, the desired result may be relatively subtle. The treatment plan should follow the patient — not the other way around.

The appeal of avoiding surgery — and the downtime that comes with it

For many patients, the biggest appeal of a non-surgical approach is not simply avoiding an operation. It is avoiding the disruption that can come with surgery.

Surgical buttock enhancement can involve a significant recovery period. Patients may need to modify their normal activities, manage discomfort and follow specific post-operative instructions while the body heals. As with any surgical procedure, there are also potential complications associated with surgery that need to be discussed carefully during the consultation.

For the right patient, one of the most significant advantages of an injectable approach is therefore **downtime**.

With DBL™, the objective is to provide buttock enhancement without the recovery period associated with a surgical procedure. While every patient responds differently and aftercare advice should always be followed, many patients are able to return to their normal daily activities very quickly following treatment.

That can make a significant difference to someone's lifestyle.

A patient may be able to schedule treatment around work rather than taking an extended period away from their professional commitments. They may be able to return to their normal routine shortly afterwards, rather than planning their life around a prolonged surgical recovery. For some patients, the ability to continue with their day, potentially even meeting friends for dinner or returning to work is one of the most compelling aspects of a non-surgical approach.

This does not mean that non-surgical treatment should be presented as a risk-free alternative to surgery. It is still a medical procedure and can involve swelling, tenderness, bruising or other side effects. Appropriate patient selection, clinical assessment and aftercare remain essential.

But when comparing the two approaches, I believe **recovery deserves to be part of the conversation from the very beginning**.



Non-surgical does not mean risk-free; it requires proper anatomical understanding, sterile technique, appropriate patient selection, and complication management.

Patients are not only asking, "What result can I achieve?" They are also asking, "How much of my life will I have to put on hold to achieve it?"

For the appropriate candidate, that is where non-surgical buttock enhancement can offer a particularly compelling proposition: the ability to pursue a change in shape and proportion while minimising the interruption to everyday life.

The importance of restraint

Perhaps the most underrated skill in aesthetic medicine is knowing when to stop.

There is a temptation in body enhancement to equate a more dramatic result with a better result. Social media can reinforce this, particularly when highly edited images and extreme proportions become the reference point.

But aesthetic medicine should not be about reproducing an image from Instagram.

A successful result should work with the patient's existing anatomy.

This is why I believe proportion is going to become increasingly important in the next generation of body-contouring treatments. Patients are becoming more informed and, increasingly, they are asking for results that look natural rather than obviously treated.

That does not mean that every patient wants a subtle result. Some patients want significant enhancement, and that is a legitimate aesthetic goal. The responsibility of the practitioner is to establish whether that goal is realistic and clinically appropriate.

Where the category goes next

I expect non-surgical buttock enhancement to continue evolving as technology, injectable products and our understanding of body contouring develop.

But the future should not simply be about finding ways to inject more product. It should be about becoming better at assessing anatomy, selecting appropriate patients and using treatment strategically.

The phrase "non-surgical butt lift" makes the procedure sound like a single treatment. In reality, it represents a category of approaches with different techniques, products, indications and limitations.

For patients, this means doing more research rather than simply choosing the practitioner offering the biggest transformation or the lowest price.

For practitioners, it means recognising that treating the body requires the same level of anatomical understanding and aesthetic judgement that we apply to the face.

Ultimately, the decision between surgical and non-surgical enhancement should be based on the patient's anatomy, goals, expectations and clinical suitability but recovery should also be considered.

For many patients, achieving a meaningful aesthetic change without putting their normal life on hold is not a secondary benefit. It is the reason they choose a non-surgical approach in the first place.

The goal of buttock enhancement should not be to make everyone look the same. It should be to make the individual look more balanced, proportionate and confident in their own body.

Shape matters. Proportion matters. And increasingly, so does the time it takes to get back to living your life. ME



Dr Ducu Botoaca is a world-renowned aesthetic clinician and the Founder and Medical Director of Dr Ducu Clinics. He specialises in hair transplantation, eyebrow transplantation, non-surgical BBL and advanced aesthetic procedures, including SkinTight, his innovative skin-tightening treatment. He has trademarked his own eyebrow transplantation techniques and non-surgical BBL technique, and regularly shares his expertise at major international conferences, including the IMCAS World Congress.

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TEOXANE | AESTHETIC SKINCARE

Teoxane Introduces RHA® Topical Skin Booster, Expanding the Skin Quality Conversation to Post-Procedure Recovery

Teoxane's RHA® Topical Skin Booster targets post-procedure hydration and skin barrier recovery, extending skin quality care into post-procedure recovery.



As skin quality becomes a growing focus in aesthetic medicine, attention is expanding beyond the procedure itself to include post-procedure skin barrier hydration recovery. According to the 2025 Plastic Surgery Statistics Report published by the American Society of Plastic Surgeons (ASPS), minimally invasive procedures continue to dominate the aesthetics landscape, with hyaluronic acid fillers accounting for approximately 30% of all nonsurgical treatments performed in 2025.

Microneedling, chemical peels and energy-based treatments remain important tools for improving skin texture, firmness and overall appearance. Yet achieving optimal patient outcomes involves more than the procedure alone. How the skin is supported in the hours and days that follow is gaining attention as an important consideration in comprehensive aesthetic care.

Moving beyond the procedure: the growing importance of post-treatment recovery

Following aesthetic procedures, the skin undergoes a recovery process that can influence treatment outcomes, leading practitioners to adopt a more integrated approach to skin quality.

"The future of skin quality doesn't rely solely on the treatment performed, but also on how effectively we support the skin barrier hydration during recovery. Following procedures, the first hours represent an important period of biological activity, as hydration balance and skin barrier restoration become key considerations. By taking a more integrated approach to treatment and recovery, practitioners can make post-procedure care a more intentional part of the patient journey."

–Dr. Ted Lain, Board-Certified Dermatologist.

Introducing Teoxane RHA® Topical Skin Booster: elevating the post-procedure care

To address this evolving area of aesthetic practice, Teoxane introduces RHA® Topical Skin Booster, a sterile, professional-use solution developed for application following procedures, in accordance with its intended use.

The formulation combines 12.5% of its patented Resilient Hyaluronic Acid (RHA®)- the highest concentration of RHA® incorporated into a topical formulation by Teoxane so far, with low-molecular-weight hyaluronic acid, amino acids, antioxidants, vitamins and minerals.

Designed to support skin hydration barrier during recovery, RHA® Topical Skin Booster extends Teoxane's expertise in hyaluronic acid into professional topical care.

"What makes RHA® Topical Skin Booster particularly relevant is that it is applied after a microneedling session, at a time when post-procedure care really matters. In the before-and-after results shared at our advisory board, after three monthly sessions, we saw a visible improvement in fine lines, and the skin looked more luminous, radiant and plump. In my view, it complements the benefits of microneedling and changes how we think about what topical skin care can achieve."

–Dr. Ted Lain, Board-Certified Dermatologist

In a clinical evaluation involving subjects treated with two microneedling sessions, and followed over several weeks, both practitioner assessments and patient-reported outcomes showed improvements in hydration, radiance, smoothness and overall skin quality.

In another study conducted on living human skin explants, the complementarity of microneedling and RHA® Topical Skin Booster increased Collagen I production by 60% after five days compared with untreated skin.

The same study also demonstrated a 62% increase in endogenous hyaluronic acid production within the epidermis after five days, highlighting its potential to support skin barrier hydration repair and quality.

Advancing recovery across the Skin Quality journey

For Teoxane, RHA® Topical Skin Booster reflects a broader vision of skin quality that extends beyond the treatment itself. By bringing recovery further into the skin quality conversation, Teoxane supports a more integrated approach where aesthetic procedures, professional recovery protocols and daily skincare work together to promote long-term skin health.

ADVERTORIAL

era®

One Platform, Four Ways to Renew: Era Gives Every Patient a Resurfacing Option



Aerolase® 30 YEARS FORWARD



Afterglow® Sub-Ablative Resurfacing
24mm



Gentle Ablative Resurfacing
10mm



Deep Ablative Resurfacing
6mm



Hybrid Fractional Ablative Resurfacing
6mm, 16 microchannels

THE YES YOU COULDN'T GIVE BEFORE

Resurfacing used to be a switch: go deep and accept weeks of recovery, or stay gentle and leave corrections on the table. Fully ablative CO2 made the trade explicit: millisecond pulses that spread heat, two to four weeks of downtime, and a high risk of post-inflammatory hyperpigmentation (PIH) in melanin-rich skin. Patients who wanted a refresh got a facial, patients with darker skin got turned away, and patients with scars got a recovery they couldn't schedule.

Practices rarely lose a resurfacing patient because the treatment would not work. They lose them because they cannot take the recovery time, want something before an event, or are not ready for the full correction conversation. A declined procedure leaves no record in any report you run, but the revenue loss is real. Era ends the trade: **one platform, two systems, four Optical Modules**, each delivering the same 2940 nm energy in a different and specific way. Change the module and the practice changes what it can say yes to.

THE RENEWAL SPECTRUM

WHY IT WORKS: SPEED OVER HEAT

Era delivers high-power **2940 nm erbium energy** in **300-microsecond pulses,** with Optical Modules that span the full range of resurfacing, from sub-ablation to deep and hybrid fractional ablation. Each pulse is delivered before heat can spread, so there is no collateral damage. No anesthetic is required, recovery is measured in days, and protocols cover every skin type, Fitzpatrick I to VI. 2940 nm sits at the peak of water absorption. Less residual heat means less inflammatory load and far less heat lingering in melanin, the mechanism behind PIH in darker skin.

AFTERGLOW: RENEWAL WITHOUT THE WOUND

Afterglow Sub-Ablative Resurfacing delivers energy below the ablation threshold, a space most lasers skip. It is not full ablation and not the old non-ablative compromise. Heat contracts loose, disorganized collagen fibers and stimulates new collagen in the deep dermis; the skin is treated, not wounded. Patients leave with a warm flush, go back to their evening, and shed a fine peel over the next few days. **One protocol covers Fitzpatrick I to VI, because the energy is absorbed by water, not melanin, the constraint that keeps IPL and broadband light on lighter skin.**

Level	What it does	Best for	Social downtime	Fitzpatrick
01 Glow Afterglow Sub-Ablative Resurfacing	Energy delivered below the ablation threshold tightens and smooths skin from beneath the surface. No wound.	Radiance, tone, texture, maintenance	Slight redness for a few hours; patients return to daily activities with a glow. A light peel over 2 to 4 days.	I to VI
02 Brighten Gentle Ablative Resurfacing	A controlled superficial ablation that lifts dull, uneven surface skin in a fast full-face pass.	Dullness, tone, surface pigment, fine lines	Over a weekend	I to VI
03 Correct Deep Ablative Resurfacing	A smaller spot at higher fluence for deeper correction where the damage lives.	Established lines, scars, benign pigmented lesions	A planned recovery of days, set by depth	I to III
04 Transform Hybrid Fractional Ablative Resurfacing	A collimated full-field pass and 16 fully ablated microchannels reaching up to 160 microns, in the same pulse.	Acne scars, wrinkles, textural correction	Measured in days, not weeks	I to III

914.345.8300 information@aerolase.com aerolase.com @aerolase

Courtesy of Aerolase

The evidence is stated as studied. In a 35-subject multicenter series across **Fitzpatrick I to V** followed for a year, investigators reported improvement in texture and evenness of tone, including at the higher skin types, with one case of transient mild hyperpigmentation and no lasting complications. A 32-patient series of patients who had declined conventional ablative peeling recovered with hyperemia over 8 to 12 hours and a light peel over 2 to 4 days. Afterglow is the easiest yes in the practice and the first step toward the next one.

Afterglow Before and After
I Rejuvenation 1 TX



Photo Courtesy of Aerolase Clinical Research

GENTLE ABLATIVE RESURFACING AND DEEP ABLATIVE RESURFACING: TWO MODULES, TWO JOBS

Surface damage is spread across the whole face. Dullness, uneven tone, surface pigment and fine lines do not live in one spot, so the tool for them needs breadth and uniformity, not intensity. **The Gentle Ablative Resurfacing Optical Module** delivers an even layer of ablation edge to edge, and because each **300-microsecond** pulse finishes before heat can spread, every pulse removes the same depth as the last one. **The full face renews uniformly in one session of 10 to 20 minutes, re-epithelializes in about 48 hours, and recovers over a weekend**. With so little residual heat left in the skin, the protocol covers **Fitzpatrick I to VI**, and it is the level most patients book first.

Gentle Ablative Resurfacing Before and After
I Rejuvenation 1 TX



Photo Courtesy of Chesahna Kindred, MD

Deep damage is commonly local. Periorbital and perioral lines, ice pick and boxcar scars and benign pigmented lesions sit in small areas and need energy density, not coverage. Taking the whole face to that depth would cost the patient recovery they do not need. **The Deep Ablative Resurfacing Optical Module** puts collimated energy into precise issues, reaching deeper exactly where it is aimed. At **300 microseconds** that extra depth comes from ablation, not from heat soaking into the surrounding tissue, which is what keeps a deep pass comfortable **without anesthetic and keeps recovery in days**. Switch modules in the same session: the broad pass renews the face, the targeted pass corrects its problem zones, and the patient plans for one visit.

Deep Ablative Resurfacing Before and After
I Post-Blepharoplasty 1 TX

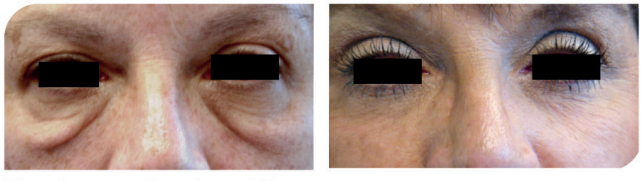


Photo Courtesy of Lopa Gupta, MD

No Era treatment requires anesthetic; the 300-microsecond pulse is comfortable enough to treat without it. Social downtime for the ablative treatments runs 2 to 7 days and is set by treatment depth; Afterglow has none. The Plume Free Cap is mandatory for Hybrid Fractional Ablative Resurfacing. Cleared indications per [510(k)]. Aerolase Era, Era Focus, Era Elite, and Afterglow are registered trademarks of Aerolase.

HYBRID FRACTIONAL ABLATIVE RESURFACING: DEPTH AND SURFACE IN A SINGLE PULSE

Acne scars form when fibrotic bands pull the skin downward, and resurfacing the surface alone can't release them. **Hybrid Fractional Ablative Resurfacing** ends the choice **between fractional depth and full-field ablation**: one pulse delivers a collimated full-field pass that treats the surface and **16 fully ablated microchannels** reaching up to **160 microns** into the dermis to drive collagen remodeling, with intact dermis between every channel. That intact dermis is why recovery is measured in days rather than weeks, and why one pass does what conventional fractional devices need a series to do.

Dr. James Gordon put it to the test live on acne scarring of the cheek. The appeal, he explained, is control: he can "*be aggressive where needed, but still keep that treatment safe, comfortable.*" His patient's verdict, with no anesthetic, was a little warmth and "*very tolerable.*"

Hybrid Fractional Before and After
I Under Eye Wrinkles 2 TX



Photo Courtesy of James Gordon, MD

THE FIFTH PATH: REVERSE SKIN RENEWAL, NEO AND ERA TOGETHER

The Renewal Spectrum delivers four levels on the Era platform. Practices that also use the Neo Elite have a fifth: **Reverse Skin Renewal, the combined Neo plus Era protocol**, performed in one visit. The Neo goes first. It delivers high power within a 650-microsecond, 1064 nm Nd:YAG pulse, below the skin's thermal relaxation time, so it calms inflammation and stimulates renewal in the dermis with no downtime, on every Fitzpatrick type. Era follows and resurfaces the epidermis. Stabilize the skin from beneath, then renew its surface: both layers treated in a single appointment, for the patient managing acne, rosacea or post-inflammatory pigment alongside rejuvenation goals.

BUILT FOR THE BUSINESS OF AESTHETICS

No numbing wait, no cooling, no recovery-room time: chair time is treatment time, and consistent no-contact delivery suits delegation within state scope-of-practice rules. Two systems run the spectrum. **Era Focus** is the entry into laser resurfacing, carrying the **Gentle Ablative Resurfacing Optical Module** with **Afterglow** as an option. **Era Elite** accepts a**ll four Optical Modules** and spans the full range of resurfacing, from sub-ablation to deep and hybrid fractional ablation. The case for either is not a projected revenue number. It is a platform that answers every resurfacing conversation in the practice, documented patient response across the spectrum, and a partnership that continues with industry-leading post-service programs.

> *After the **Era** treatment patients commonly refer to the treatment as a **magic eraser.***
>
> **James Newman**, MD, Premier Plastic Surgery

Ablation hasn't gone away. It has finally learned to listen to the patient in the chair.

See the four Optical Modules in a live demonstration on your own patients.

Book a demo at *aerolase.com/era/era* or scan the code.

Healthy Energy for All Skin.

Aerolase® 30 YEARS FORWARD

AI FACIAL ANALYSIS SHOULD PRESERVE INDIVIDUALITY

Dr. Jason Champagne

As consumer facial analysis tools gain traction, aesthetic practitioners must help patients interpret AI-generated insights without reinforcing unrealistic beauty standards or treatment expectations.



The moment an app gives a face a score, it turns curiosity into judgment. A number suggests that a person is being measured against one ideal, with variation treated as a flaw. Facial analysis can do better. It can help people understand proportion, symmetry, and change without telling them how close they are to a perfect face.

I created REPHINE as an educational way for people to explore their facial features. A user takes or uploads a photograph, and the application examines facial landmarks and the visual relationships among features. It offers insights about symmetry, balance, brow position, jawline definition, and proportion. The word insights is deliberate. REPHINE does not recommend procedures, diagnose a condition, or determine whether someone is a candidate for treatment.

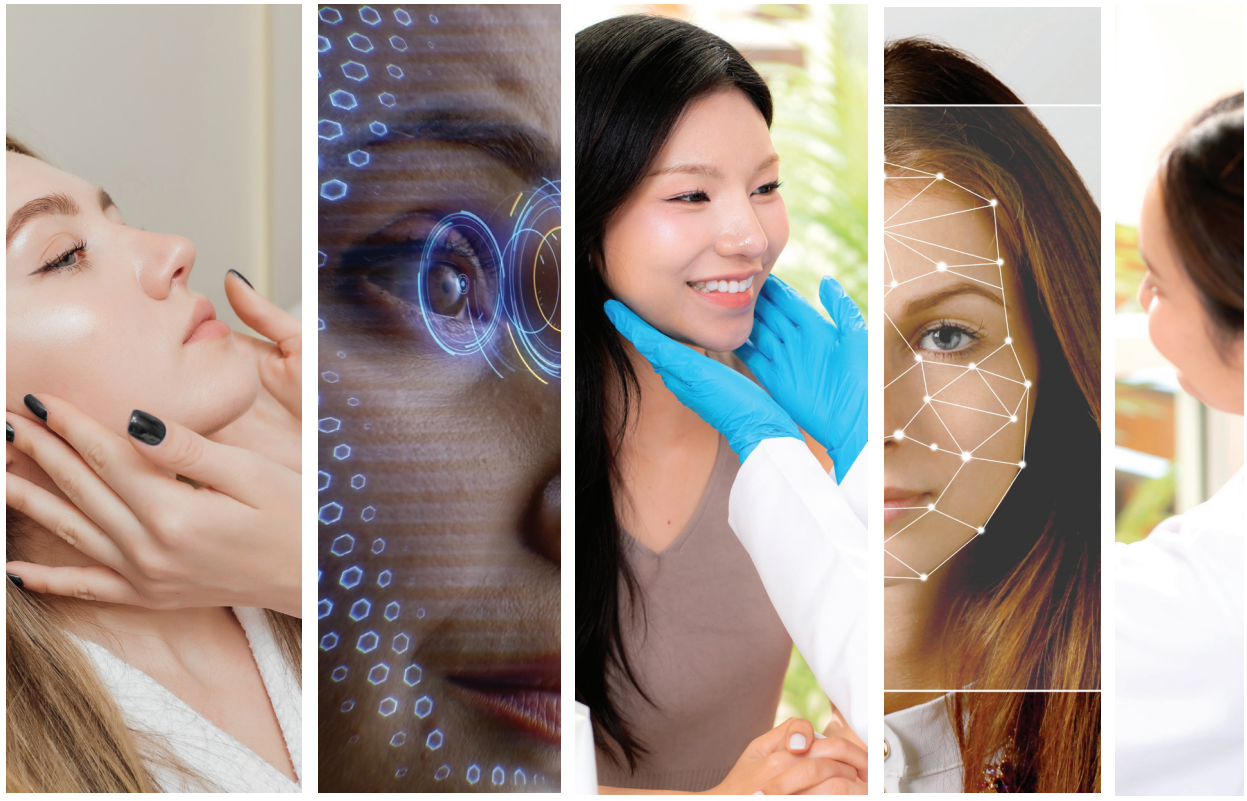
That restraint was part of the design from the beginning. Curiosity does not automatically mean dissatisfaction, and an analysis should not manufacture a problem for a user to solve. A person may open the app to understand why features stand out or how the face reads as a whole.

A photograph contains far less information than it appears to. Lighting can change the apparent depth of a feature. Camera angle and lens perspective can alter proportions. Facial expression can affect symmetry. Even a clear photograph cannot reveal skin and soft tissue quality, bone structure, medical history, personal goals, or the many other factors a qualified practitioner considers during an examination.

AI can identify and explain visual relationships, but its interpretation should not be confused with a physician's evaluation. Used responsibly, it can give people new language for questions they may want to ask. The medical decisions still belong in a consultation where the practitioner can examine the patient, listen to the patient's concerns, and consider the complete clinical picture.

Image by master1305 at Adobe Stock





Facial aesthetics should respect the structure and identity of the individual rather than push every patient toward the same proportions.

The same caution applies to aging visualization. REPHINE offers an AI interpretation of how a face may change over time. It is exploratory, not predictive. Genetics, sun exposure, daily habits, and changes in skin, soft tissue, and bone all affect how a person ages. A visualization may prompt curiosity, but it cannot forecast an individual outcome.

The more difficult question for facial analysis technology is the standard it uses. Many beauty filters and scoring tools imply that there is one correct face. They reward movement toward a shared template, even though real faces vary across age, sex, ethnicity, anatomy, and personal identity. Social media already places considerable pressure on people to resemble the same edited images. AI can intensify that pressure when it treats difference as a defect.

My main requirement for REPHINE was that it not compare every user with a single ideal. The application looks at how one person's features relate to one another. This follows the same principle I use in practice. Facial aesthetics should respect the structure and identity of the individual rather than push every patient toward the same proportions.

For aesthetic professionals, this boundary deserves attention as consumer AI tools become more common. Patients may arrive with reports, altered photographs, or unfamiliar terms generated by an application. We should be prepared to explain which observations are useful, which are affected by the photograph, and which require an examination. Dismissing the technology entirely will not stop patients from using it. Clear guidance can keep curiosity from turning into misplaced certainty.

AI has a useful role in education, visualization, and explaining complex ideas. It should help people understand their faces without telling them that they need to be fixed. The standard for responsible facial analysis should be simple: preserve individuality, state the limits of the image, and leave medical judgment to qualified practitioners. ME



Dr. Jason Champagne is a double board-certified facial plastic surgeon in Beverly Hills who built REPHINE, an AI tool that maps and plans facial procedures with far more precision than the eyeball-it method most of the field still relies on. He's spent more than a decade developing signature techniques like his SignatureSculpt rhinoplasty, and his work has been featured in Vogue and The Hollywood Reporter.

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†Based on total revenue of Ultherapy® + Ultherapy PRIME® as of Sept. 2025.
‡Not recommended for those with significant weight loss resulting in pronounced skin laxity.[1]

Actual patient. Individual results may vary. Posterior arms not treated.

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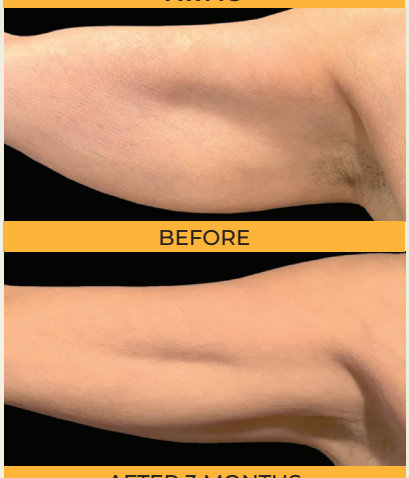

Actual patient. Individual results may vary. Anterior arms treated.

ABDOMEN



Actual patient. Individual results may vary. Abdomen treated.

KNEES



Actual patient. Individual results may vary. Knees treated.

The Ulthera® System is U.S. FDA-cleared to lift the eyebrow, the skin on the neck and under the chin, as well as to improve lines and wrinkles on the décolleté, and to improve the appearance of skin laxity on the abdomen, anterior arms, posterior arms and knees.

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References: 1. Ulthera® Instructions for Use. **2.** Marquardt K, et al. *J Cosmet Dermatol.* 2025;24(1):e16638. **3.** Park JY, et al. *J Clin Aesthet Dermatol.* 2021;14(5):E70-E79. **4.** Sasaki GH, Tevez A. *J Cosmet Dermatol Sci Appl.* 2012;02(02):108-116. **5.** Vachiramon V, et al. *Lasers Surg Med.* 2021;53(4):476-481. **6.** Lin FG. *Dermatol Surg.* 2020;46(12):1683-1690.

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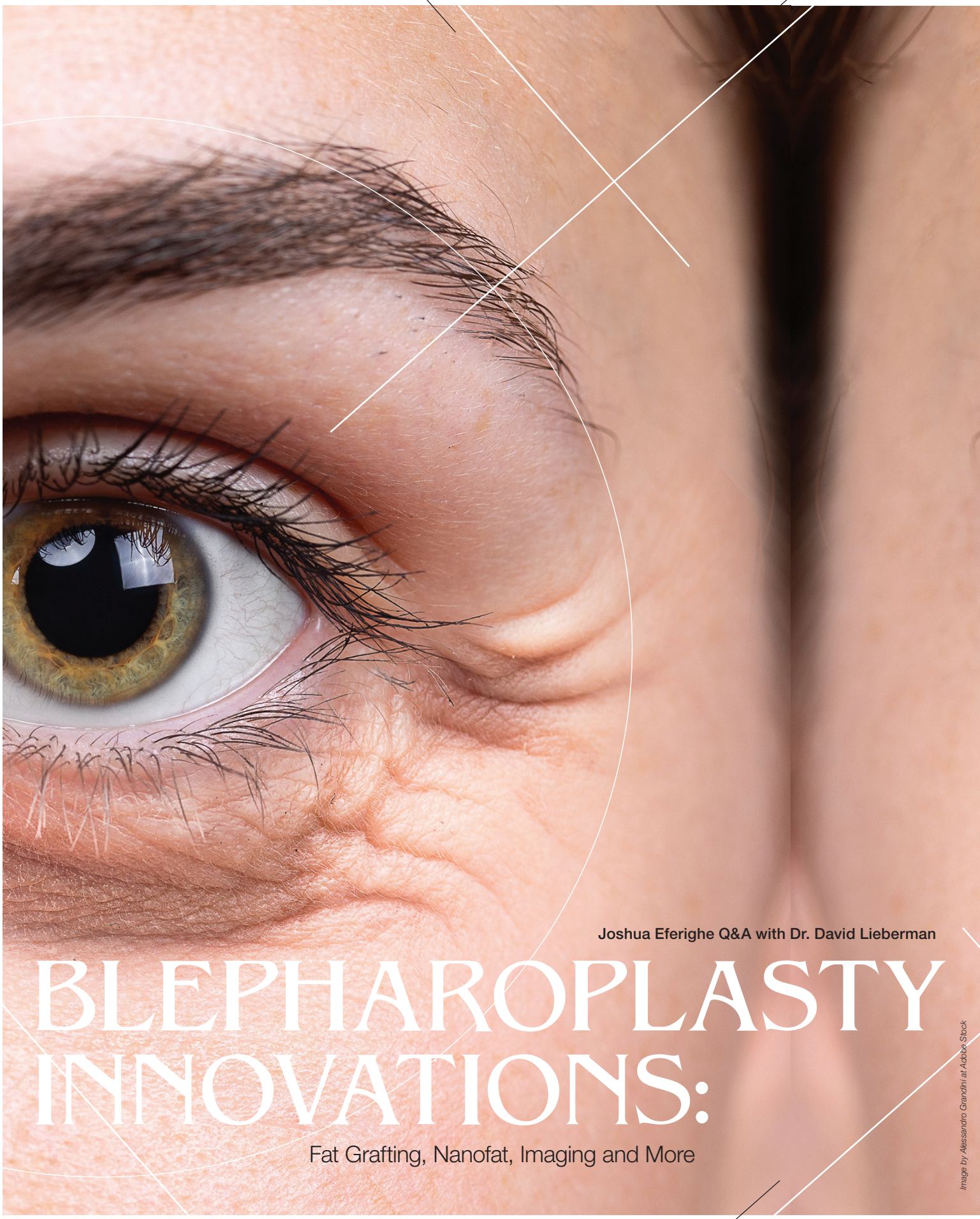


Joshua Eferighe Q&A with Dr. David Lieberman

BLEPHAROPLASTY INNOVATIONS:

Fat Grafting, Nanofat, Imaging and More

Image by Alessandro Grandini at Adobe Stock



Blepharoplasty is evolving beyond the traditional approach of removing excess skin and fat. Today, surgeons are increasingly focused on preserving or restoring volume, addressing the relationship between the eyelids, brow and surrounding structures, and tailoring techniques to each patient's anatomy and aesthetic goals. Additive blepharoplasty, fat grafting, nanofat, regenerative modalities and advanced imaging are becoming part of a broader conversation around how to achieve natural-looking, long-term results while avoiding an overly hollow or operated appearance.

To explore how these techniques are being applied in practice, MedEsthetics spoke with Dr. David Lieberman, double board-certified plastic surgeon and medical director at L&P Aesthetics, about his approach to blepharoplasty, including volume restoration, nanofat, regenerative treatments, preoperative imaging, laser resurfacing and the changing demographics of eyelid surgery patients.

Do you use additive blepharoplasty, combining skin removal with fat grafting? If so, what does that combination let you achieve that skin removal alone doesn't?

A youthful presentation of the eyes is not just about removing age-related change. Treating the volume loss due to soft tissue and bone change is essential. This is always true for the lower eyelid complex but also applies to the upper eyelids. Descent of the brow complex and volume change at the junction of the brow, and the eyelid are central components of age-related change. Neglecting volume issues in the upper eyelid complex can lead to a skeletonized and hollow appearance, even aging the appearance. To comprehensively address the upper eyelid complex we typically combine a brow reshaping procedure (here the youthful relationship between the soft tissue of the brow and the orbital bone is restored), fat grafting around the brow and in the hollow between the brow and the eyelid, and upper blepharoplasty. In our upper blepharoplasty, while excess skin is removed, the muscle and youthful fatty volume is preserved by design. When the fat pad by the nose is prominent, this is contoured appropriately.

When you use autologous fat rich in stem cells for that grafting, what changes for the patient in terms of natural volume, fine lines, and skin quality over time?

The biggest thing we see over time is very natural volume restoration. Once the transferred fat has settled, the portion that survives integrates into the surrounding tissue and can provide long-lasting correction. Patients may also see some softening of fine lines and improvement in the overall appearance and quality of their skin, but we consider those secondary benefits.

Do you use nano lipofilling for dark circles or under eye concerns? If so, why has it become a go to for that specifically?

Fat grafting in any area is a multi-level procedure. For the lower eyelids and the lid-cheek junction, our primary goal is to restore the deeper volume loss due to bone changes and soft tissue loss. Here we use structural fat placed in very small aliquots (amounts) directly on the bone. This is precise and strategic to maximize survival, optimize contour, and minimize any change of irregularity. Occasionally, we also use nano-fat to focus on texture changes and superficial volume changes. This is especially powerful when we are simultaneously doing laser resurfacing as it helps with healing and the long-term outcome.

How does that regenerative effect show up for patients? Are we talking pigmentation, radiance, both?

It can be a combination of both. Patients may notice that the under-eye skin looks brighter and more even in tone, with improvements in texture and fine lines that give the area an overall healthier appearance.

Do you incorporate PRP, exosomes, or nanofat into your practice? If so, where does each fit and what is it doing that the others aren't?

We currently use nanofat, but we don't incorporate PRP or exosomes into our surgical practice. Nanofat fits more naturally into our surgical approach because we can harvest the patient's own fat during a procedure and use it very selectively in areas where we're looking to improve fine lines, texture and overall skin quality without adding significant volume. We do use PRP during our brow reshaping and deep plane face lifting procedures to help boost the tissues for healing. We also use many of the regenerative modalities in our nonsurgical practice.

How do these regenerative additions change healing time or the durability of a result compared to surgery alone?

We don't necessarily look at regenerative modalities as a way to make the surgical result last longer. A case can be made that appropriate use of regenerative treatments can help with healing time frames and boost the cellular mechanisms to combat the aging process. The longevity of the result still comes primarily from the surgery itself (soft tissue repositioning/lifting, volumizing procedures). For us, nanofat is more about complementing that result by addressing skin quality, texture and color. Those changes can continue to become more apparent as the area heals, and the final surgical result settles.

Do you use imaging or visualization tools like Crisalix or VECTRA with patients before surgery? If so, what does that actually change about the consultation?

We use the Visia imaging prior to any deep resurfacing so we can demonstrate change and learn from our procedures as we continually work to optimize our protocols.

Why does that kind of preop planning matter for aligning a result with someone's actual anatomy and goals?

Preoperative imaging gives us another way to understand what a patient is seeing, what they hope to change and how that relates to their individual anatomy. It creates a much more specific conversation around proportions, asymmetries and realistic goals before we ever enter the operating room.

Do you perform laser blepharoplasty using CO2 or erbium lasers? If so, how does it compare on bleeding, swelling, and downtime versus traditional methods?

We don't use CO2 or erbium lasers to perform the blepharoplasty itself. Our surgical technique is still performed with traditional instruments, and we use laser resurfacing around the eyes as a complementary treatment. We have several laser modalities' that we adapt to a patient's skin type and expectations for healing and outcome.

Circle back to additive blepharoplasty. From a technique standpoint, how does combining skin removal with fat grafting change the outcome versus doing them separately?

Doing them together allows us to balance removal and restoration in the same procedure. That gives us greater control over the final contour and helps avoid an overly hollow appearance. We really treat the area as a whole rather than correcting excess skin and volume loss as two separate problems.



The longevity of the result still comes primarily from the surgery itself.

Are you familiar with or do you use Ziplyft? If so, what's the appeal of a sutureless, no stitches approach for patients?

We're familiar with Ziplyft, but it's not a technique we currently use in our practice. We understand the appeal of a sutureless approach from a patient perspective, however our priority is choosing the technique that gives us the greatest control and consistency for each patient's anatomy.

Are you seeing more men come in for eyelid surgery? What's driving that shift?

Yes, we're definitely seeing more men interested in eyelid surgery. One patient told us that the shift to Zoom and working remotely meant he was suddenly looking at his own face for hours a day, which made him more aware of changes to his face. More broadly, we think men are becoming increasingly comfortable seeking aesthetic treatments while still wanting results that are subtle and don't look obviously surgical.

What does that expanded patient base, beyond women in their 30s to 50s, mean for how you approach these consultations?

Our approach really hasn't changed because we've always treated these consultations as highly individualized. We're looking at the patient's anatomy, how they're aging, what specifically bothers them and what they hope to achieve, not their age or gender. As the patient base expands, that individualized approach becomes even more important because there simply isn't a one-size-fits-all procedure. No matter what procedure a patient is having in our practice, we know we are intervening at a certain point in their aesthetic journey. It is our responsibility to treat them as if we were taking care of them for their lifetime- making smart long-term decisions for that particular person.

Are younger patients starting to come in earlier for procedures like blepharoplasty in your practice?

Yes, we are seeing younger patients come in for blepharoplasty, but their motivations are often different from those of older patients. They may have genetically prominent under-eye bags, naturally heavy upper lids, or hollowness. We also believe the increased transparency around aesthetic surgery online has made younger patients more aware of their options and more comfortable exploring them.

If so, how do you frame early intervention for a younger patient who isn't dealing with obvious sagging yet? What are you actually preventing?

We don't typically frame blepharoplasty in younger patients as a preventative procedure. If there isn't significant age-related sagging yet, we're usually addressing an existing anatomical concern rather than trying to prevent something from developing later. The benefit of intervening earlier for the right patient is that we can often make a very targeted, conservative change while preserving as much of their natural anatomy as possible. ME

Joshua Eferighe is the managing editor of *MedEsthetics.*

Image by Rabizo Anatolii; Rabizo Anatolii; Vera; puhhha at Adobe Stock

ETHICS IN PLA

Informed Consent, Patient Expectations and Responsible Care

A few years ago, patients came in and described what bothered them. Now they come in with a picture. Sometimes it's an influencer. Sometimes it's a filtered selfie of their own face, smoothed and reshaped by an app into someone who doesn't quite exist. Lately it's an AI-generated portrait of an "ideal" version of themselves that no anatomy could actually produce. The request has quietly shifted from "here's what bothers me" to "make me look like this." That shift is why I think our field needs to talk about ethics directly and out loud, rather than assuming it comes bundled with good work.

We tend to treat ethics as the quiet backdrop behind technical skill. However, technical skill has never been the vulnerable point. You can execute a flawless procedure the patient should never have had. The vulnerable point is the conversation before it. That conversation has gotten harder because the person across from me now arrives with expectations built somewhere I wasn't in the room: a feed, a filter, a friend's result, a cup size chosen from a photo. That's as true for a breast augmentation as it is for a facelift. The procedure on the table almost doesn't matter. The ethical work is the same, and it happens at the very start of the encounter.

So let me say what an ethical consultation actually looks like on my end, because we often describe it too abstractly. When a patient sits down, I'm listening for the why underneath the what. A patient can ask me for a breast augmentation, but my job is not to quote a price and book a date. My job is to understand what they believe that operation will do for them, because sometimes the honest answer is that it will do very little for the thing actually bothering them. I'm listening for whether the expectation is achievable, whether the request suits the human in front of me, and whether they're driven by something they've long wanted or something

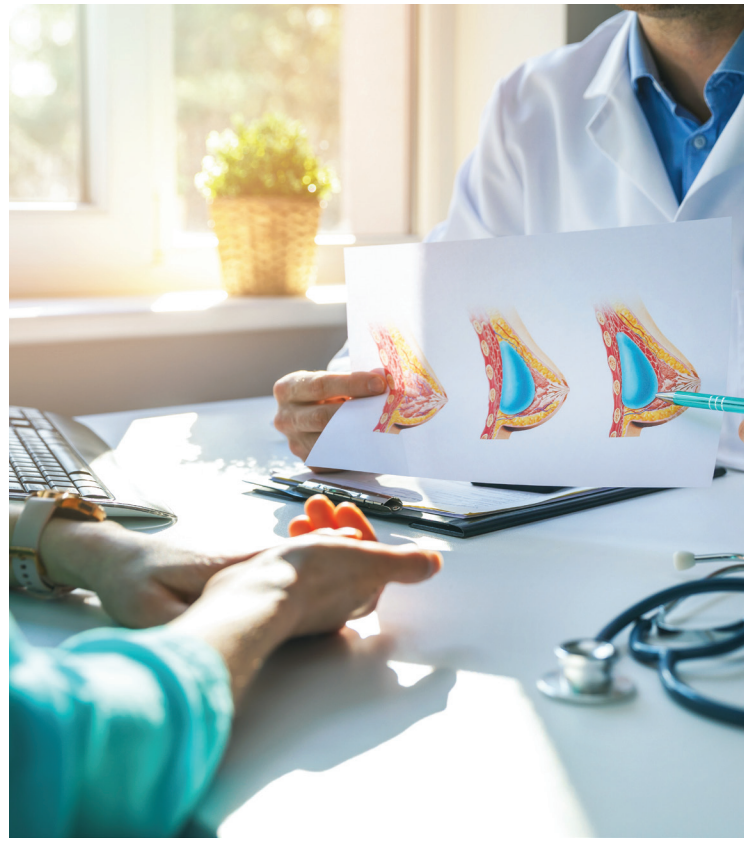


Image by Monkey Business at Adobe Stock

STIC SURGERY:

Dr. Gina Maccarone




Nobody should leave my consultation feeling foolish for what they walked in believing.

they absorbed last week. Also, there are definitely things I'm NOT doing. I'm not steering someone toward a bigger procedure than they need because it's a bigger case. I'm not adding the second procedure that happens to pad the invoice. I'm not letting the fact that I could do something become the reason I should.

Part of my job is setting expectations honestly, but I won't do it by shaming the patient. Someone who walks in wanting to look like a filtered image has not failed morally. They've been swimming in a distorted standard for years, on every screen they own, and it would be strange if it hadn't shaped them. Meeting that with condescension, or an eye-roll at the influencer photo, is both cruel and useless. You may say, "What?! Who does that?!" Believe me, there are surgeons in my field who behave this way. Every patient should be approached with respect: to say, gently and clearly, "Here's what's real, here's what I can actually do, and here's what that picture is hiding from you." That's true for the patient wanting one modest change and equally true for the one set on a major operation. Nobody should leave my consultation feeling foolish for what they walked in believing. They should leave understanding more than they did before.

Let me give one example. A young woman came to me set on a very large breast augmentation. She'd researched it thoroughly, chosen a size from images she'd saved, and arrived having essentially prescribed the operation for herself. But the size she wanted didn't suit her frame, and it carried real long-term consequences she hadn't considered, the kind that lead to more surgery down the road. The easy thing, the profitable thing, was to agree and book it. Instead I told her I didn't think that size was right for her, and walked her through why: what her body could carry well, a more proportionate approach that would still give her the change she wanted, and the honest downside of going bigger than her frame supported. She was frustrated in the room. She'd come in with a plan and I'd taken it apart. She left to think. I accept that maybe I wasn't the surgeon for her, but my job is to educate my patients so we can be a team. She came back a few weeks later, and we did the more conservative version, and she's elated with her results.

That example really concerns informed consent, which is far larger than the signature we collect. The form documents the consent; it doesn't create it. Real informed consent means the patient understands what they're

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signing up for: what recovery genuinely feels like, what the realistic result is rather than the best-case photo, what the procedure will not fix, and what happens if they later want it undone. It also means grasping the gravity of the thing itself. We've let people approach surgery with a casualness it never earns, booking an operation the way they'd book a blowout. I find myself saying it plainly, often: this is an operation, not a haircut. If someone can consent to going under anesthesia without truly absorbing that, we collected a signature and skipped the consent.

Because before I am anything else in that room, I am a physician. I took an oath to do no harm, and I hold to it, which means a real part of my work is protecting patients, even from themselves. That is where I think too much of this industry, on the surgical side and the injectable side alike, has lost the thread: it runs on sales. The recurring pattern is the recommendation shaped by what's profitable rather than what's right. Overpromising results we can't reliably deliver. Pressuring people with urgency and packages. Running the same one-size template across every body. Letting the financial upside quietly author the plan. I'm not pointing at any one clinic. I'm naming a structural pull, because our advice and our revenue come out of the same mouth, and pretending we don't feel that pull is exactly how it wins.

So what I'd most want to change is how our field talks about ethics, which is to say that we barely do. Many surgeons don't trade techniques freely because they want to preserve "competition" and stay oddly quiet on the even harder questions: when not to operate, how to price without pressure, how to handle the patient we could help but probably shouldn't. We've let a strange divide harden, where some surgeons practice with tunnel vision instead of learning from each other. Why wouldn't we all want to be better, and help each other do so? Medicine is always changing and improving. It also all carries risk, and it all deserves the same honesty. That's a conversation I want to have with my peers, not just with patients.

So if I could leave a patient with one thing to look for, in any office, for any procedure, it's this: find the provider willing to talk you out of something. The one who asks why before quoting what, who offers you the smaller option, who is visibly willing to lose your business rather than sell you a result you don't need. A provider comfortable telling you no is showing you the one thing marketing can't fake, that your safety and your outcome matter to them more than your appointment does. Everything ethical in this field starts there. ME



Dr. Gina Maccarone Triple Board-Certified Cosmetic Surgeon and Founder of The Surgeonista.

NON-SURGICAL BUTT LIFT MYTHS: WHAT PROVIDERS NEED TO KNOW ABOUT VOLUME, RESULTS AND SAFETY

From filler volume to “no-risk” claims, experts break down the biggest misconceptions surrounding non-surgical buttock enhancement.

Joshua Eferighe Q&A with Dr. Joshua C. Kreithen, of Holcomb-Kreithen Plastic Surgery & MedSpa

The “non-surgical butt lift” has become a catchall term for a growing range of aesthetic treatments, from injectable biostimulators and muscle stimulation to skin-tightening technologies and combination approaches.

The marketing shorthand, however, obscures an important distinction: these treatments are not interchangeable or is a substitute for surgical buttock augmentation or lifting.

For providers, understanding what each procedure accomplishes is critical to patient outcomes and satisfaction.

MedEsthetics spoke with Dr. Joshua C. Kreithen, of Holcomb-Kreithen Plastic Surgery & MedSpa about the biggest misconceptions surrounding non-surgical buttock enhancement, including what today’s treatments can realistically achieve, the limits of injectable volume, the role of biostimulators and muscle stimulation, safety considerations, patient selection and when surgery needs to enter the conversation.



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Let's start with the biggest misconception: What exactly does "non-surgical butt lift" mean today, and what can these treatments realistically accomplish that a surgical BBL or buttock lift cannot?

Let's consider the phrase "non-surgical butt lift" cautiously, as it's become a marketing umbrella. It can refer to several interventions, including injectable treatments, collagen stimulation, skin-tightening technology, muscle stimulation, cellulite release, or combinations of several approaches. Considered less invasive than what is called a Brazilian Butt Lift (BBL), these treatments may improve contour, add modest volume, smooth a transition, firm the skin, or sharpen muscle definition rather than adding a large amount of fat-transferred volume.

Myth or fact: A non-surgical butt lift can produce the same degree of lift, projection and contouring as a surgical Brazilian butt lift. Where does that comparison break down?

Myth. A Brazilian Butt Lift is essentially the harvesting of excess fat cells from other parts of the body and then injecting them into the buttock area for more projection and volume. Depending on the technique and volume transferred, there may or may not be significant lifting. The average amount of fat transferred in a BBL is 300–600 cc per side (about 1 pound), which is more volume than can be achieved with non-surgical options. In terms of comparison, the minimally invasive options provide modest contour changes, improve shallow depressions and mild skin concerns, and benefit patients who accept a smaller result.

What are the primary modalities you're using or seeing for non-surgical buttock enhancement today, including injectables, biostimulators, energy-based devices, and muscle stimulation, and what does each actually do to the tissue?

In terms of non-surgical options, the two most common minimally invasive treatments, in my opinion, are injectable volumizing agents and muscle stimulation. In our office, we use Sculptra and Emsculpt frequently, often in conjunction with each other.

Sculptra's active ingredient is poly-L-lactic acid (PLLA), and it biostimulates by stimulating fibroblasts deep in the subcutaneous tissue to produce new collagen over time. Over a period of several weeks to a few months, we see gradual volume enhancement, improved skin thickness/quality, and some softening of contour irregularities. Depending on how much improvement is desired, multiple treatments may be needed.

Emsculpt is a non-invasive treatment that provides muscle stimulation, with a recommended 4–6 treatments once weekly for best results. The technology uses paddles that deliver high-intensity focused electromagnetic energy (HIFEM) to trigger thousands of contractions of the gluteal muscles. Essentially, it's like doing thousands of squats. As the muscles hypertrophy, they become firmer and larger, and the entire buttock becomes rounder, tighter, and more elevated.

How do you determine whether a patient is better suited for filler/biostimulation, an energy-based treatment, a combination approach or surgery?

Every treatment plan is centered upon listening carefully to what a patient wants, assessing their anatomy, and then discussing the best ways to achieve a desired result while setting realistic expectations. I will say that most of the patients we are now seeing who come in desiring a "butt lift" have lost significant weight (via GLP-1s) and don't have enough fat elsewhere on their body to do a BBL. These patients obviously are candidates for the less invasive treatments we have been discussing; however, many of them also have so much loose skin that a lower body lift (360-degree skin removal) enters the conversation.

As for candidates for a BBL, it's important to discuss in depth the recovery and potential for complications. BBL recovery is demanding, and most patients need a couple of weeks before they are comfortable enough to return to normal activity, and they need to sleep on their stomach for several weeks to maximize fat-grafting survival. Also, the BBL has a higher complication rate than most other plastic surgery procedures, including seroma, infection, contour irregularities, fat necrosis, wound problems, and pulmonary fat embolism.

Patient selection seems particularly important with buttock enhancement. What anatomical or physiological factors make someone a strong candidate for a non-surgical approach, and who is likely to be disappointed by the results?

The strongest candidates are healthy non-smokers at a stable weight, realistic about their expectations, and comfortable with a result that may require upkeep. Good skin quality always helps. A localized hollow, mild asymmetry, early laxity, or a limited contour concern may be reasonable to address with non-surgical approaches. It's critical for patients to be educated and to understand the number of sessions, cost, cumulative time, and potentially temporary nature of a result. One of the most common





BBL recovery is demanding, and most patients need a couple of weeks before they feel comfortable returning to normal activity.

phrases used with plastic surgery lifting procedures in any situation is that "we can't stop aging or gravity." Disappointment is more likely with substantial sagging, heavy excess skin, severe deflation, major weight-loss changes, or an expectation of surgical projection.

Myth or fact: More product equals more projection. What are the limitations and safety considerations around trying to create significant volume non-surgically?

Myth. More injectable product is not a good strategy. The buttock is a large area, so chasing dramatic projection with injectables can require a very large amount and can be excessively costly. Rather than advising more product, a better strategy is to combine muscle stimulation with targeted biostimulation.

How much of the "lift" patients see from non-surgical treatments is actually increased volume versus skin tightening, tissue remodeling or improved muscle tone?

It absolutely depends on the treatment, and there are multiple factors that go into the buttock lift equation. In my opinion, it really comes down to physics and anatomy. For example, by increasing the size and mass of the gluteal muscle, with the potentially added biostimulation from Sculptra, the loose skin of the lower buttock will lift upward to a degree dependent on the increase in volume. The amount of lift the patient sees will be directly proportional to the improvement in total volume.

What should practitioners consider when treating different concerns such as loss of volume, skin laxity, cellulite, asymmetry, or lack of projection? Can one modality realistically address all of these?

No single modality reliably treats all of them: volume loss, loose skin, cellulite, asymmetry, and poor projection are all different diagnoses. Cellulite usually involves releasing fibrous bands tethering the skin, so simply filling the area may soften a shadow without correcting the cause. Asymmetry can come from fat distribution, muscle, the pelvis, the spine, or suboptimal prior treatments. Mild laxity may improve with skin-tightening injections or microneedling/radiofrequency, while substantial laxity requires an honest surgical discussion.

There's understandably a lot of attention around gluteal injectables. What are the most important anatomical and safety considerations practitioners need to understand before treating this area?

Gluteal injections are a serious medical procedure. The area contains large vessels, nerves, and muscles. A practitioner needs the correct three-dimensional anatomical knowledge, a clear understanding of injectable dynamics, strict sterile technique, and proper communication regarding aftercare and follow-up. Liquid silicone, oils, unknown materials, or products from an unverified source have no place here. With a known history of many fat embolism complications, surgical fat grafting is typically done with subcutaneous placement above the fascia

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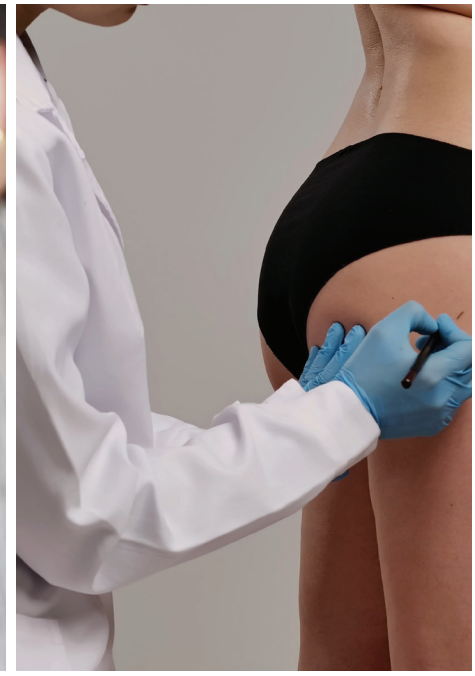

Non-surgical buttock treatment results should not be presented as permanent.

using real-time ultrasound. Training and technique cannot be improvised.

What are some of the biggest red flags you see in the way non-surgical butt lifts are marketed to consumers?

The biggest red flags are things like the unethical marketing of a "surgical BBL without surgery," dramatic same-day projection, and permanent results. I would also be concerned when a practitioner is vague about the product, calls it "organic" or "medical-grade" without naming it, or will not discuss whether the use is FDA-approved. Bargain packages built around several vials are another warning.

Myth or fact: Because a treatment is "non-surgical," it is inherently low-risk. What risks or complications should practitioners discuss during informed consent?

Fact. In my opinion, "non-surgical" options for buttock treatments have a much lower risk of complications than a BBL. For example, Emsculpt, which is an external treatment, has a very minimal risk of adverse reactions. Biostimulator injections like Sculptra and Radiesse have an inherently low risk when performed correctly by a skilled clinician. Skin-tightening devices like Morpheus also carry low risk. With injectables, I do discuss during the informed consent process bruising, swelling, and pain as more common potential issues, and infection, asymmetry, nodules, granulomas, migration, inflammatory reactions, and tissue loss as very rare complications.

How should providers counsel patients about maintenance? Are these results generally temporary, and what determines how long they last?

Non-surgical buttock treatment results should not be presented as permanent. Although fillers and biostimulators can sometimes lead to some permanence, most are gradually broken down over time. Skin tightening fades as aging, weight change, and gravity continue. Muscle-based results require continued exercise and often yearly maintenance treatments. Longevity depends on multiple factors, including tissue quality, metabolism, weight stability, activity level, and treatment schedule. Because gluteal filler is not FDA-approved for body contouring and is considered "off-label," practitioners should be careful about making claims borrowed from facial indications. I always discuss the possibility of additional treatments before the first treatment, not after the result begins to fade.

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What does a responsible treatment plan look like when a patient wants a dramatic transformation but their anatomy or treatment options won't realistically support it?

The key is an open, honest, transparent discussion with a review of realistic expectations. Once you perform a treatment on a patient, you essentially enter a medicolegal clinician-patient contract. So, if a patient's anatomy does not support the result being requested, a responsible clinician shouldn't perform the incorrect

procedure. In the medical field, "the customer is always right" doesn't apply. For example, if I have a weight-loss patient who comes in wanting a BBL and doesn't have any significant fat to harvest, I will recommend other options like Sculptra, Emsculpt, or even a lower body lift in certain situations. Sometimes, the responsible plan is no treatment.

Are there cases where you would tell a patient, "A non-surgical approach isn't the right tool for this job"? What are the signs that surgery should be part of the conversation?

Absolutely. Significant skin excess, a low or distorted infragluteal fold, major deflation after weight loss, or a request for substantial projection are signs that surgery belongs in the conversation. I do find that a series of Emsculpt treatments usually helps with some projection and lift in most cases. Appropriate surgical candidacy still depends on health status, donor fat and tissue quality, smoking status, willingness to accept scars, and tolerance for recovery. If a patient isn't a good surgical candidate, that doesn't make a non-surgical substitute equally effective in terms of achieving a good result.

Finally, what do you think aesthetic providers most need to understand about the non-surgical butt lift as the category continues to evolve?

There's an old saying, "When all you have is a hammer, everything looks like a nail." When we apply this to non-surgical buttock lifting, it's important to have several tools in the tool chest to address different issues. If someone is promoting these treatments, it's worth having skill in multiple modalities, including biostimulators, muscle stimulation, and skin tightening, to address several diagnoses that drive patients to an aesthetic office. Also, from personal experience, with more than 25 years in cosmetic surgery, I've learned that restraint is also a technical skill. Just because you can do something doesn't mean you should.

Myth Questions

Myth: "Non-surgical means no downtime and no real risk." What's wrong with that statement?

There is never "no downtime" and "no real risk" with almost anything. Although non-surgical buttock lift techniques have much less downtime and risk than a BBL, there are still some inherent risks/complications and some downtime. All injection procedures have normal aftereffects like swelling, soreness, and bruising, which can lead to some downtime. Also, there is some inherent risk with injectables and energy devices that we have discussed previously.

Myth: "You can build a surgical-level buttock with enough filler." What does a provider need to understand about the limits of injectable volume?

No. The buttock is a large anatomic unit. Creating surgical-level projection (300+ cc) would require a very large and unrealistic amount of injectable volume, with rising costs and increasing exposure to infection, nodules, inflammation, migration, pressure-related problems, asymmetry, and vascular injury. In our office, we will combine muscle stimulation with injectable biostimulators, which in some cases can approach surgical levels of overall volume as the muscle significantly hypertrophies.

Myth: "Every patient asking for a butt lift needs more volume." How often is the actual issue skin laxity, cellulite, proportions or something else?

Very often. "I need a butt lift" may mean a patient dislikes several issues, including unflattering shadows, a hip dip, widespread cellulite, loose or crepey skin, stretch marks, a heavy lower fold or gluteal crease, or the transition from waist to hip. More volume may help one or more of those concerns and worsen another. The key is to examine the patient standing from several angles, then look at skin, fat, muscle, and skeletal proportion. Sometimes the right answer is targeted cellulite work, a skin-tightening treatment, injectable biostimulation, muscle stimulation, contouring around the buttock, an operation, or no procedure. If the diagnosis is wrong, more volume simply gives the wrong problem a larger outline. ME

Joshua Eferighe is the managing editor of *MedEsthetics.*

NAVIGATING THE OVERINFORMED PATIENT IN AESTHETIC MEDICINE

Dr. Scott R. Miller

Learn how practitioners can manage overinformed patients, correct misconceptions and align treatment expectations with clinical realities to improve consultations and patient satisfaction.

In the era of viral TikTok trends, AI-generated idealizations, and online forum deep-dives, prospective aesthetic patients often enter my consultation room feeling as if they are fully educated. Armed with hours of digital research, not to mention knowledge "pearls" from friends, many believe they already possess expert-level insight into surgical techniques, recovery protocols, and target outcomes.

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When patients believe they know everything about plastic surgery or non-invasive options, the consultation workflow is destined to break down.

For practitioners, this dynamic introduces a clinical and communication hurdle commonly known as the Dunning-Kruger Effect.

First identified by psychologists David Dunning and Justin Kruger, this cognitive bias describes a phenomenon where individuals with limited expertise drastically overestimate their mastery of a complex subject. Because these patients "know just enough" to feel confident, they remain unaware of the vast anatomical, surgical, and physiological blind spots in their understanding.

In aesthetic medicine, where managing tissue behavior, managing surgical risk, and setting realistic expectations dictate success, the Dunning-Kruger Effect is not merely an inconvenience. It is a primary driver of post-treatment dissatisfaction and revision requests.

The Clinical Risks of Patient Overconfidence

The reality here is that the general patient population does not have a clear enough understanding of the processes and procedures that go into cosmetic surgery. In fact, one of the reasons I wrote my book "Authentic Beauty" is to help those considering elective cosmetic surgery understand how to gather reliable information, make informed decisions and ensure the best possible results from their surgery.

When patients believe they already know everything about plastic surgery or non-invasive options, the consultation workflow often breaks down in one or more of the following ways:

- Resistance to Medical Guidance: Overconfident patients frequently skip foundational questions and dismiss practitioner feedback regarding anatomical limitations, tissue quality, or contraindications.
- Flawed Baseline Assumptions: Believing a specific procedure will yield identical results as it did for a friend or coworker creates a disconnect between medical reality and their personal expectations.
- Elevated Revision and Dissatisfaction Rates: Erroneous assumptions inevitably lead to unrealistic goals. When surgical or clinical outcomes align with immutable and unavoidable physical and physiological reality rather than their pre-conceived belief, dissatisfaction is almost guaranteed.

Re-establishing the Consultation Framework

To protect patient safety, safeguard practice reputation, and optimize outcomes, providers must guide overconfident patients away from passive assumptions and toward humbler, active engagement.

Educating patients to approach their journey with personal agency requires shifting them from a mindset of "I know what I need" to a curious disciplined decision-making framework by all parties:

- Ask: Encouraging structured, targeted questions rather than passive agreement.
- Listen & Learn: Creating room for the patient to absorb clinical rationale regarding surgical approach and risk factors.
- Ask Again: Normalizing follow-up questions to resolve lingering misconceptions.
- Receive & Digest: Giving the patient time to process realistic expectations away from social media influence.

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- Integrate & Consider: Aligning clinical advice with their lifestyle and personal goals.
- Decide: Reaching an informed decision rooted in shared decision-making rather than unexamined assumptions.

Knowledge is Power—When Paired with Humility

Empowerment in aesthetic medicine does not come from self-diagnosis or internet mastery; it comes from active, humble collaboration between patient and provider. True patient agency is found when the patient stops curating an idealized image and starts prioritizing their unique, biological reality.

I always encourage patients to look beyond the algorithmic trends and embrace an aesthetic journey grounded in self-awareness and sustainable health. By helping patients move away from the "search-engine-expert" trap and toward this more balanced perspective, we can align their goals with what is anatomically achievable and psychologically rewarding.

By identifying the Dunning-Kruger Effect early in the consultation phase, aesthetic practitioners can actively redirect unrealistic expectations, protect surgical integrity, and foster long-term trust. Don't let patients assume expertise; guide them to approach their care with curiosity and informed humility. ME



Dr. Scott R. Miller, board-certified plastic surgeon, author of the Amazon bestseller "Authentic Beauty", and founder of Miller Cosmetic Surgery Center in La Jolla, CA. Consistently rated as one of Southern California's leading surgeons, Dr. Miller is highly sought after for his focus on natural-looking facial rejuvenation, patient safety, and aesthetic artistry. Patients travel from around the world for procedures with Dr. Miller and some of the procedures he specializes in include: facelift surgery, rhinoplasty, breast augmentation, liposculpture, tummy tuck surgery, structural fat grafting, and personalized skin care, among many other treatments.

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ENDOSCOPIC FACE LIFTS: CANDIDATES, BENEFITS, RECOVERY AND RESULTS

An endoscopic midface lift can reposition cheek tissues through concealed incisions for patients seeking targeted facial rejuvenation.

Dr. Anthony Admire

Patients often come in asking, "What can I do before I need a facelift?" There is a broad spectrum of options. Non-invasive treatments can improve skin quality and, in selected patients, provide modest tightening. Injectables can soften expression lines or restore lost volume. These treatments have value, but they have limits when the underlying issue is tissue that has descended with age.

Minimally invasive surgical techniques offer a middle path for appropriately selected patients. An endoscopic midface lift is a good example: it allows me to reposition the mid-face cheek tissues through small, concealed incisions in the hair-bearing scalp. It is still surgery, but it can address a specific structural change without the incisions and skin removal associated with a more comprehensive facelift.

The ideal candidate has noticed early to moderate descent of the cheeks but still has reasonably good skin elasticity and relatively little excess skin. They may describe flatter cheeks, early jowling, a more pronounced transition between the lower eyelid and cheek, or a tired appearance that does not reflect how they feel.

This often includes patients in their late 30s, 40s, and early 50s, although anatomy matters much more than a birthday. Some younger patients do not need surgery at all, while some older patients remain suitable candidates for a targeted approach.

The distinction I look for is whether we primarily need to reposition tissue or also remove substantial excess skin. When significant jowling, loose neck skin, or deeper neck changes are present, an isolated endoscopic midface lift will not adequately address those concerns. That patient may be better served by a comprehensive facelift and necklift. Choosing the appropriate operation is far more important than choosing the smallest incision.

I start by asking what the patient sees and what bothers them. "I look tired" can mean several different things: cheek descent, volume loss, lower eyelid changes, brow position, or sun-damaged skin. Those problems require different solutions.

I assess the face as a whole, including cheek position, skin elasticity, facial volume, lower eyelid support, brow position, jawline, and neck. We review photographs (as well as the patient's own photos taken 10-20 years ago) and discuss the patient's medical history, previous surgery, fillers or other treatments, medications, and nicotine



The biggest misconception is that a small incision means a small recovery.

use. Understanding their health and their expectations is essential.

Then I explain what an endoscopic midface lift could realistically improve, and which concerns would remain. If volume loss is also important, we may discuss conservative fat grafting. If brow descent or eyelid aging contributes to the tired appearance, those areas deserve their own assessment.

Before moving forward, the patient needs to understand the alternatives, anesthesia plan, risks, recovery, and follow-up care. My goal is for them to make an informed decision with a clear understanding of why this particular approach fits their anatomy.

An endoscope is a slender instrument with a small camera that gives me an illuminated, magnified view beneath the skin. Through small incisions concealed within the hair-bearing scalp near the temples, we can carefully release the attachments restricting movement of the cheek tissues, elevate those tissues, and secure them in a more youthful position. The precise access and fixation method vary with the technique and the patient's anatomy.

In accessible terms, I am lifting the cheek's existing soft tissue back toward where it used to sit. That can restore cheek contour and improve the transition between the lower eyelid and cheek.

A conventional comprehensive facelift generally uses incisions around the ears, allows broader treatment of the lower face, and permits removal of excess skin. The endoscopic midface lift is more targeted. It does not replace a full facelift or necklift when those procedures are needed.

The hidden incisions are an advantage, but the real value is the ability to reposition deeper tissues under direct visualization. "Hidden" also does not mean scar-free; incision planning must account for the patient's hairline and hair density.

The biggest misconception is that a small incision means a small recovery. We are still working beneath the skin and repositioning tissue, so swelling, bruising, tightness, and temporary changes in sensation can occur. The cheeks and under-eye area may look puffy or unusually elevated early on.

A reasonable planning window is approximately two weeks away from public-facing work and social commitments, with some patients needing longer. Being comfortable working from home is different from feeling ready for photographs or an important event. Residual swelling can persist for several weeks, and the result continues to soften and settle over the following months.

Recovery also depends on whether we combine the lift with other procedures. Patients receive specific instructions

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about incision care, sleeping position, activity restrictions, and a gradual return to exercise.

I also discuss risks openly, including bleeding, infection, asymmetry, scarring or hair loss near an incision, nerve injury, and the possibility of revision. Smaller incisions do not eliminate surgical risk. Close follow-up and knowing when to contact the surgical team are part of the treatment.

At AdmireMD, my goal is for patients to look like themselves - refreshed, balanced, and naturally rejuvenated. An endoscopic technique is one valuable tool within that philosophy, and its success begins with selecting the right patient.

I think about facial rejuvenation in three connected areas: tissue position, volume, and skin quality. A lift addresses position. Carefully selected volume restoration may address deflation. An individualized skin optimization plan addresses texture, pigmentation, sun damage, and ongoing skin health.

Natural, enduring results come from understanding how those pieces fit together and supporting patients over time. No procedure stops aging, and no single technology addresses every aspect of it. The best plan is the one that respects the patient's anatomy, preserves their identity, and makes sense for where they are in the aging process. ME



Dr. Anthony Admire is a board-certified plastic surgeon and facial rejuvenation specialist, and founder of AdmireMD Plastic Surgery + Skin Clinic in Scottsdale and Phoenix, Arizona. With more than 20 years of experience, he is best known for his expertise in extended deep plane facelift and deep neck lift techniques. A faculty member at the University of Arizona College of Medicine–Phoenix and frequent national and international lecturer, he has built a comprehensive model of care that integrates surgical expertise with skin optimization for natural, lasting results..





THE LASER SAFETYCOMPLIANCE GAP PUTTING MEDSPAS AT RISK

by Anastasia Andreani

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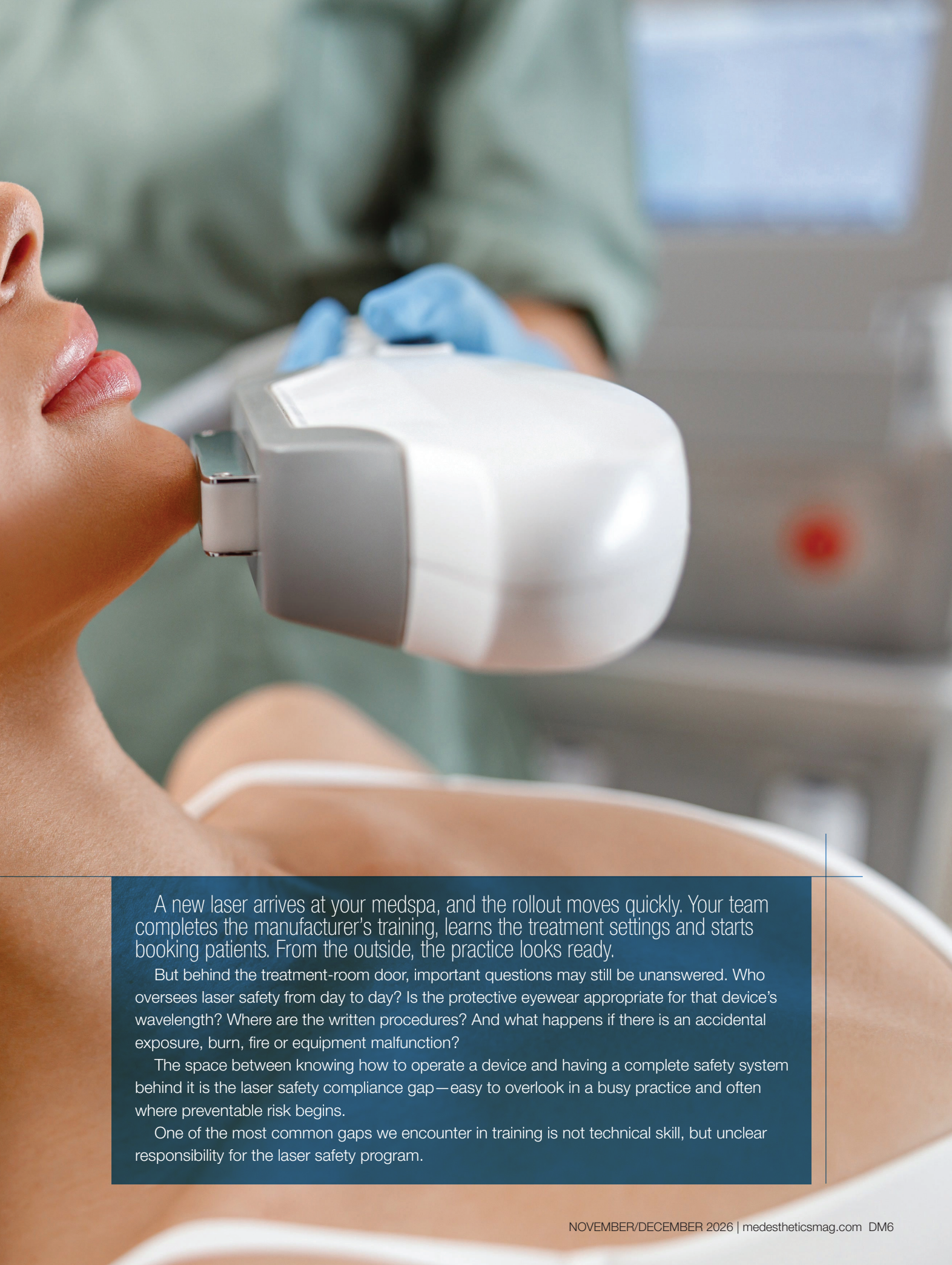


A new laser arrives at your medspa, and the rollout moves quickly. Your team completes the manufacturer's training, learns the treatment settings and starts booking patients. From the outside, the practice looks ready.

But behind the treatment-room door, important questions may still be unanswered. Who oversees laser safety from day to day? Is the protective eyewear appropriate for that device's wavelength? Where are the written procedures? And what happens if there is an accidental exposure, burn, fire or equipment malfunction?

The space between knowing how to operate a device and having a complete safety system behind it is the laser safety compliance gap—easy to overlook in a busy practice and often where preventable risk begins.

One of the most common gaps we encounter in training is not technical skill, but unclear responsibility for the laser safety program.



Laser-safety problems rarely begin as dramatic failures. More often, they start as small inconsistencies.

Operating the Device Is Only the Beginning

Manufacturer education is essential, but it generally focuses on operating equipment and performing treatments. A laser safety program is broader, covering the treatment environment, staff responsibilities, hazard controls, documentation and emergency response.

Class 3B and Class 4 laser systems can cause serious eye and skin injuries. Class 4 systems may also create reflected-beam and fire risks. Those hazards require controls around the room, the equipment and everyone who enters the treatment area.

Energy-based devices should not be treated as though they are all the same. Intense pulsed light, radiofrequency and ultrasound are different technologies, each with its own hazards, operating considerations and manufacturer instructions. A well-run practice inventories each device separately and builds procedures around the technology being used.

ANSI Z136.3: Your Framework, Not Your Only Rulebook

ANSI Z136.3, Safe Use of Lasers in Health Care, is a widely recognized consensus standard for laser safety in healthcare settings. The 2024 edition provides a framework for cosmetic, diagnostic, therapeutic and preventive laser use, including hazard evaluation, controlled areas, protective eyewear, staff education, equipment maintenance and incident response.

ANSI standards are voluntary consensus standards, not OSHA regulations by themselves. OSHA does, however, identify the ANSI Z136 series as a source of guidance for protecting workers from laser hazards.

No single checklist covers every requirement. Federal product rules, workplace-safety obligations, state scope-of-practice laws, facility requirements, manufacturer instructions and insurance conditions may all apply. State rules may also address operator credentials, medical supervision, delegation, facility registration or written treatment protocols.

ANSI Z136.3 provides a strong framework, but every practice must still verify the requirements governing its location, services and staff.

The LSO Is a Job, Not a Certificate

A Laser Safety Officer, or LSO, oversees the facility's laser safety program and helps ensure that known hazards are identified and controlled. In a smaller practice, the role may be assigned to a qualified team member. Larger organizations may require oversight across several rooms, devices or locations.

Responsibilities may include maintaining the device inventory, establishing laser-controlled areas, confirming

Image by Марина Десятниченко, Andrey Popov st.kolesnikov at Adobe Stock

that protective eyewear matches the wavelength and required optical density, developing written procedures, coordinating staff education, reviewing maintenance records and investigating suspected exposures or incidents.

The position must also come with authority. An LSO who identifies an unsafe condition needs to be able to pause treatment until the issue is corrected.

A medical director may serve as the LSO when properly trained and formally assigned, but the roles are not automatically interchangeable. Medical oversight and laser-safety oversight involve different responsibilities, even when one qualified person performs both.

The same principle applies to vendors. Equipment representatives and outside trainers can be valuable resources, but they do not manage your daily safety program. Once training ends, the facility still needs its own policies, oversight and documentation.

"Patients assume that any practice using a laser has a real safety program behind it," says Stephen Fink, DO, FAOCO, a board-certified facial plastic surgeon. "A trained Laser Safety Officer isn't a formality—it protects the patient, the staff and the practice itself."

How Small Gaps Become Big Liabilities

Laser-safety problems rarely begin as dramatic failures. More often, they start as small inconsistencies.

One employee checks the eyewear label; another reaches for the pair that looks familiar. One room posts the warning sign only during treatment; another leaves it up around the clock. Maintenance is completed, but no one can quickly locate the service record.

These gaps matter when you are hiring, adding equipment, opening another location, renewing insurance, responding to an employee injury or facing a licensing inquiry. Documentation will not prevent every adverse event, but it can show that your practice recognized known hazards, trained its team and created a reasonable system to manage them.

Six Steps to Close the Gap

- Build a complete device inventory. Record the manufacturer, model, serial number, technology, wavelength or energy type, hazard classification and service history for every laser and energy-based device. Follow the manufacturer's maintenance schedule, document repairs and confirm that equipment is safe before returning it to service.
- Verify state law and scope of practice. Rules may address licensing, delegation, supervision, facility registration, operator training and written protocols. A course certificate or manufacturer training does not expand a provider's legal scope of practice.
- Formally designate a qualified LSO. Put the assignment in writing. Make sure the person understands your devices, has appropriate laser-safety education and can stop unsafe activity.
- Write device-specific procedures. Do not rely on one broad policy for every machine. Address setup, access control, eyewear, pre-treatment checks, emergency shutdown, fire precautions, maintenance, incident reporting and plume control when applicable. Where appropriate, keep a current, device-specific quick-reference protocol at the point of use to reduce setup and parameter-selection errors.
- Audit each treatment room. Confirm that protective eyewear matches the device's wavelength and required optical density, warning signs are used correctly, access is controlled, emergency controls are accessible and fire precautions are in place. Keep flammable products and materials away from the treatment area, and ensure appropriate fire-response equipment is readily accessible. Eyewear should never be selected by tint or appearance alone.
- Train, document and reassess. Anyone who operates lasers or enters a controlled area should understand eye and skin hazards, room controls, emergency shutdown, fire risk and incident reporting. Record the date, topic and participants for each training session, and review the program whenever devices, staffing or locations change.

Build the Program Before You Need It

Energy-based treatments can support a med spa's clinical and financial growth, but every new device brings responsibilities beyond treatment settings and technique.

A strong laser safety program does not need to create unnecessary bureaucracy. It should create clarity: who is responsible, which procedures must be followed, how staff are trained and where important records can be found.

The question is no longer simply whether your team knows how to operate a laser. It is whether your practice has built the safety infrastructure needed to support that technology responsibly. ME



Anastasia Andreani, CLSO, is a licensed esthetician, Certified Laser Safety Officer, and co-founder and president of AML Laser Academy. With more than 20 years of experience in medical aesthetics and spa operations, she develops curriculum and professional education for aesthetic practitioners and med spa teams. Her work focuses on laser safety, energy-based treatments, staff education, and the practical systems needed to support safe, responsible practice.



The New Standard in Facial Surgery:

Why the Best Facelift Looks Like Nothing Was Done

Dr. Michelle Lee, board-certified plastic surgeon and founder of PERK Plastic Surgery, offers an insider's perspective on the evolving standard for facial rejuvenation—and why today's most sophisticated facelift results may be the ones that never announce themselves.

In the following op-ed, Lee explores the shift toward natural-looking facial surgery, earlier intervention, deeper structural correction and a more longitudinal approach to aesthetic care.

The most common thing patients say to me after a successful facelift is not "I look younger." It's "I look like myself again." That distinction is everything. Undetectable, to me, doesn't mean invisible intervention, it means the result is so congruent with who that person is that no one can locate the surgery. They just see a face that looks rested, vital, and alive.

Technically, it means incision lines disappear because there is no tension pulling at the skin, and contour is restored without the face feeling or looking tight. It is a face in harmony. That is the new standard of success, and frankly, it should always have been. We're simply now at a moment in medicine where the technique, the technology, and the cultural conversation have caught up to what patients have wanted all along.

What I'm seeing in my practice is a fundamental shift in sophistication. Patients are arriving with reference photos not of celebrities, but of themselves: A vacation photo from ten years ago, a wedding picture, a screenshot of a candid where they felt luminous. They're not chasing someone else's face; they're trying to recover their own.

They're also asking better questions. One unexpected driver of this shift is physician presence on social media. When surgeons share educational content about anatomy, aging, and surgical technique, it raises the baseline of what patients understand before they ever walk into a consultation. Patients today know what a facelift can and cannot do. They understand that surgery addresses structure, but skin quality requires ongoing care. They understand volume replacement but can understand the consequences of too much filler. They want to understand the anatomy behind the aging they're seeing, and they can distinguish between structural changes and those driven by volume loss or skin quality. That kind of patient engagement tells me the conversation has matured. We're no longer talking about surface corrections. We're talking about biological age versus chronological age and patients understand the difference.

One of the most meaningful shifts in my practice is that patients are coming in earlier, and that's producing the most natural results I've ever achieved. When I see someone in their forties before significant structural changes have set in, I'm working with tissue that still has elasticity, vascularity, and regenerative capacity. I'm making smaller moves with longer lasting impact. We address early jowling, repositioning soft tissue at a point when the face's underlying architecture is still largely intact. The result looks natural because it is natural. We're not reversing a decade of change; we're maintaining a trajectory.

Technology has also expanded what's possible in terms of both precision and recovery. Imaging tools that let me

Images courtesy of the author

assess soft tissue in three dimensions, regenerative adjuncts like fat grafting that bring living biology rather than inert filler to volume restoration, and refined anesthesia protocols that allow faster recovery.

Deep plane facelift techniques that allow restoration of the face by releasing retaining ligaments.

90% of our patients undergo deep sedation anesthesia for facelift which is a lighter anesthesia than endotracheal intubation. Advanced postoperative protocols such as hyperbaric oxygen treatments allow for faster healing. All of these contribute to outcomes that are cleaner, more individualized, and less disruptive. Less trauma to tissue means less inflammation, less inflammation means faster healing, and faster healing means the result resolves beautifully rather than through a prolonged and visible recovery. The window between intervention and invisibility has narrowed dramatically, and that matters enormously to the modern patient.



What the best facial surgery actually requires is restraint. The single dramatic intervention, the transformative "before and after," has largely given way to a more nuanced approach: a layered, longitudinal approach that respects the face as a system. I think of it in decades. What I do today has to hold up ten years from now. That means addressing the deep structural layers where aging actually begins, not just the surface. A facelift that only tightens skin creates a face that will re-age asymmetrically. A deep plane approach that repositions the underlying SMAS and soft tissue creates a foundation that lasts and moves naturally, which is the thing people notice most when something has been done poorly.

I want patients and the public to understand that an undetectable result is not a lesser result. It is actually the hardest result to achieve. It requires anatomical knowledge, surgical experience, and a kind of aesthetic confidence that doesn't need to leave a signature. Anyone can make a change that's visible. It takes real expertise to make a change that looks inevitable like it was always supposed to look this way. The consultation matters as much as the operating room. I need to understand not just what a patient's face is doing biologically, but how they see themselves, how they want to move through the world, and what their face means to them. That's not a peripheral conversation. It's the center of everything.

Facial surgery is heading toward biology, toward longevity, toward results that are measured not by how much was changed but by how well the face holds its story. It's not about looking thirty when you're fifty. It's about looking like the healthiest, most vital version of yourself at every decade. My practice philosophy has always been: I treat now, I think in decades. That's not a slogan. It's a framework for how I believe this specialty should operate and where I believe it's finally, meaningfully headed. ME



Dr. Michelle Lee is a board-certified and Ivy League-trained plastic surgeon behind some of the most natural-appearing facial surgeries in the industry. Dr. Lee starred on E! Entertainment's Dr. 90210, where she was the only surgeon performing facial procedures, including facelifts, noninvasive facial rejuvenation, and rhinoplasty. Castle Connolly also selects her as one of the Top plastic surgeons in the country. Dr. Lee has over 20 peer-reviewed publications in plastic surgery published in the top plastic surgery journals. For a full list of Dr. Michelle Lee's peer-reviewed publications, visit her Google Scholar profile. She created PERK plastic surgery to align with her philosophy that life is too short to settle for anything less than the most extraordinary version of yourself. PERK practices integrative beauty where aesthetic maintenance and enhancement are part of a lifestyle continuum that includes self-care in all areas. We believe beauty is a collective experience; when we feel beautiful, we are more productive members of society. When we invest in ourselves, we invest in our community..



Dr. Anil Shah Challenges Conventional Approaches to Lower-Eyelid and Neck Rejuvenation

At Facial Aesthetics: Deep Plane and Beyond, Shah explored how anatomical preservation, muscle repositioning and volume restoration can inform surgical planning.

On September 12–13, 2026, double board-certified facial plastic surgeon and researcher Dr. Anil Shah joined an international faculty at Facial Aesthetics: Deep Plane and Beyond in Porto, Portugal, where he presented approaches to lower-eyelid and neck rejuvenation that challenge conventional ideas about tissue removal, volume, and surgical planning.

Invited by renowned facial plastic surgeon Dr. Mike Nayak, Shah delivered three presentations examining the anatomy behind facial aging and the role of preservation, repositioning and restoration in surgical planning.

For the lower eyelid, Shah presented a preservation-focused technique that maintains the orbicularis muscle while using three small conjunctival openings to address and reposition fat internally. He argues that postoperative complications are not simply a matter of how much tissue is removed, but can result from scarring within the lamella.

His neck work focused on the hyoid bone and infrahyoid strap muscles, examining how changes in their position may influence neck contour. The research underscores why patients with similar aesthetic concerns may require different surgical plans based on their underlying anatomy.

Shah also challenged the idea that neck rejuvenation should always mean subtracting volume. Excess fat can obscure the jawline, but superficial volume loss can also contribute to an aged appearance. His approach combines selective reduction with restoration where appropriate.

More broadly, Shah describes facial rejuvenation as an exercise in muscular and structural rebalancing. Muscles age differently depending on how they are anchored, he says, making it difficult to treat the face as a single problem with a single procedure.

That philosophy also informs his approach to assessment. Shah advocates evaluating patients upright and examining the neck dynamically, rather than relying solely on an assessment made with the patient supine.

MedEsthetics spoke with Dr. Shah about the anatomical principles behind his approach, the assumptions practitioners should reconsider, and the research questions that could shape future approaches to facial and neck rejuvenation.

Q&A With Dr. Anil Shah

1. What assumptions about facial rejuvenation should practitioners reconsider?

The biggest one is that aging is mainly a story of skin laxity and volume loss, and that the fix is to tighten or fill. My view is that facial rejuvenation is fundamentally an exercise in muscular and structural rebalancing. Muscles age differently because they are anchored differently. A muscle fixed to bone at both ends, like the temporalis or masseter, essentially doesn't descend. A muscle anchored at one end holds there while its soft-tissue end drifts. A muscle anchored to





soft tissue at both ends, like the orbicularis oris or platysma, descends as a unit. If you accept that, you can't treat the face as one problem with one operation.

The second assumption is that it's the amount of tissue that you remove on the lower eye that causes problems. Oftentimes it's scarring within the lamella. By actively treating the patient with techniques that avoid scarring within layers, you can create safe, consistent results that are reliable and still impactful.

The third is that we can judge a face lying down. We mark fat upright and then lose that information the moment the patient is supine. Nobody injects filler lying flat, yet we routinely finish surgery that way.

2. What did the discussion of preservation, repositioning and restoration reveal about assessment and planning?

It showed that each of those words belongs to a different part of the face, and assessment has to start by asking which one applies where. The lower eyelid is a preservation problem. The orbicularis isn't redundant; a single drop of Botox can produce ectropion. So you protect innervation, the middle and posterior lamellae, and the capsulopalpebral fascia, and you take out only what's in excess. The face and lip are repositioning problems: the platysma and orbicularis oris have descended, so you lift the muscle and, where possible, secure it to periosteum rather than soft tissue. The neck is a restoration problem. The infrahyoid straps shorten and need lengthening, and the neck paradoxically has too much deep fat and too little superficial fat, so it needs remodeling and addition at the same time.

Practically, that means evaluating patients upright, examining the neck dynamically (having them protrude the tongue shows hyoid movement), and planning the case as an orchestration of several targeted moves rather than choosing one signature procedure.

3. Did the conference change how you think about the aging eye or neck, or point to research needs?

On the eye, the conversation reinforced something I find unsettling: posterior and middle lamellar shortening shows up even in the best hands, and it's easy to mistake for a skin deficit. When I talk to surgeons, you would assume that the transconjunctival blepharoplasty is a safe technique. However, when I spoke to them, many talked about how they are all having problems with slight lash position issues, subtle retraction issues. It reinforced that my technique was both new and needed to make eye surgery safer.

On the neck, infrahyoid strap muscle anatomy remains essentially very limited, and that's where I'd most like to see research. My myotomy data, 50 patients with release and 50 without, is being submitted, but it needs independent replication. I currently have over 500 patients which is by far the largest series with this technique. This is the only technique that I knew of that could actually improve the airway as well, and is actually the only technique that changes the hyoid position. Surgeons here seem to be really proud of their work on the neck and I'm happy for them. However, if you objectively looked at their necks on their pictures, they were proud of, oftentimes the hyoid position was not changed. It can be intimidating to learn a new technique. I'm hoping that this will teach surgeons safe and impactful surgery for improving patient's lives. ME

Joshua Eferighe is the associate managing editor of *MedEsthetics.*

Images courtesy of Dr. Anil Shah

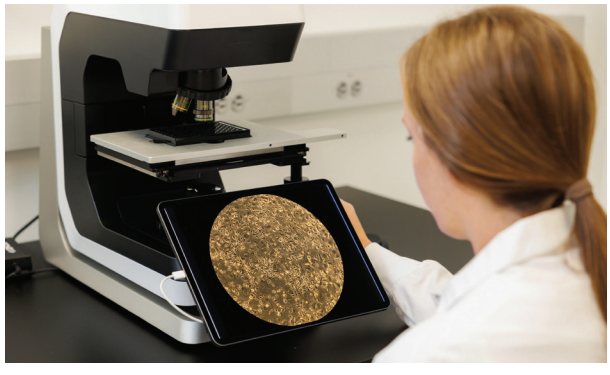
ALLERGAN AESTHETICS STUDIES EVALUATE SKIN QUALITY TREATMENTS AFTER MEDICAL WEIGHT LOSS



On September 17, 2026, Allergan Aesthetics announced results from two single-center clinical studies evaluating targeted skincare regimens alone and in combination with DiamondGlow® dermabrasion treatments in individuals taking medical weight loss (MWL) medications, including glucagon-like peptide-1 receptor agonists (GLP-1 RAs). Presented at the Science of Skin Summit (SSS), Sept. 17-20, 2026, in Austin, Texas, the 12-week skincare study showed statistically significant, investigator-assessed improvements in selected skin quality measures across the face, neck, upper inner arms, and distal thighs. The skincare regimen included a growth factor serum, a neck cream and a firming and toning body lotion.

The study is especially relevant because GLP-1 and other medical weight loss therapies are reshaping the aesthetic patient population and practices increasingly look for ways to address concerns beyond facial volume loss, including laxity, crepiness, texture, and overall skin quality.

DEBUT LAUNCHES BIOTECH INGREDIENT PNAR FOR HYPERPIGMENTATION AND SKIN BRIGHTENING



On September 15, 2026, biotech company Debut announced the launch of DermCeutical PNar™, a biotech active engineered to visibly reduce hyperpigmentation and brighten the skin without the irritation commonly associated with the industry's most widely used, higher-concentration ingredients such as kojic acid.

PNar™ was developed through Debut's proprietary platform and integrates AI, skin genomics, and biotechnology. Engineered by identifying the underlying biological drivers of hyperpigmentation and designing an entirely new molecule to target them at the source, the ingredient blocks key enzymes, including tyrosinase, to reduce melanin production before dark spots appear.

The development comes as hyperpigmentation remains a major treatment challenge, particularly for practices treating diverse skin tones, and ingredient innovation could expand the tools available for managing uneven pigmentation. In a company-reported 12-week clinical study, 97% of participants showed improvement in hyperpigmentation and 88% showed improved skin brightening. The ingredient's low use level and focus on precision targeting also highlight the growing intersection of biotech and professional skincare formulation.

NEW DEEP PLANE FACELIFT TECHNIQUE REFINES TISSUE FIXATION AND POSTOPERATIVE RECOVERY



On September, 10, 2026, Double Board-Certified facial plastic and reconstructive surgeon Sam Rizk, MD, FACS, introduced a novel modification to the deep plane facelift focused on how tissues are entered and secured, with the goal of improving the durability of results while supporting a more efficient recovery. First demonstrated live at the prestigious 2025 Baker Gordon Symposium, Dr. Rizk's surgical technique modifies the entry point into the deep plane and uses non-cable suturing to secure repositioned tissues rather than relying on traditional cable-like suture configurations

As deep plane facelift techniques continue to evolve, facial plastic surgeons are looking beyond simply repositioning tissue to how they secure and maintain it over time. For aesthetic physicians tracking advances in surgical facial rejuvenation, the approach highlights the ongoing focus on anatomical precision, fixation strategy and recovery.

Images courtesy of manufacturers

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