Avoiding Dermal Filler Pitfalls Begins With a Mirror

BY DOUG BRUNK
San Diego Bureau

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

“I can’t tell you how many times I have looked at the patient on a consult, assessed precisely what I thought was realistic, and then be told that it’s actually something completely different that they are here for me to treat,” Dr. Hirsch said at the annual meeting of the American Society of Cosmetic Dermatology and Aesthetic Surgery.

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

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

Permanent fillers also require more time to inject, which makes them an unattractive option for hurried patients who want a true “lunchtime” procedure. “You shouldn’t use permanent filler before you get to know your patient,” Dr. Hirsch advised. “Temporary fillers give you an idea of how they’re going to comply and respond.”

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

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

Permanent fillers can be used appropriately in defects that are pliable enough so that when elevated the surrounding tissue is unaffected. They should not be used in areas where the skin is thin and hyperdissensible. “Supernormal defects” are very easy to overcorrect with permanent fillers, and if you do, it’s there for good,” Dr. Hirsch said.

“You can have delayed excessive fibrosis, particularly in high tension areas like the lips. And the implant may become visible as patients age.”

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

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

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

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

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

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

Dr. Duff had no relevant conflicts of interest to disclose.

Most Defects Don’t Justify Permanent Filler Use

BY DOUG BRUNK
San Diego Bureau

Las Vegas — In Dr. David M. Duffy’s opinion, the perfect cosmetic filler doesn’t exist and probably never will.

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

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

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

Permanent fillers also require more time to inject, which makes them an unattractive option for hurried patients who want a true “lunchtime” procedure. “You shouldn’t use permanent filler before you get to know your patient,” Dr. Duffy advised. “Temporary fillers give you an idea of how they’re going to comply and respond.”

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Dr. Duff had no relevant conflicts of interest to disclose.

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

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

If blanching or pain occurs at the injection site, stop immediately, because this can be the only sign of an impending vascular injury. Immediate administration of heat, massage, and nitroglycerin paste helps minimize or reverse permanent injury. A recent case report demonstrated that immediate administration of hyaluronidase can also be of great value (J. Drugs Derma tol. 2007;6:325-8). Once the vascular accident is witnessed by someone and time stamped. These are critical aspects.” She advised checking with an attorney and the risk is particularly prominent for the physician, not the patient.”

Dr. Duff had no relevant conflicts of interest to disclose.

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