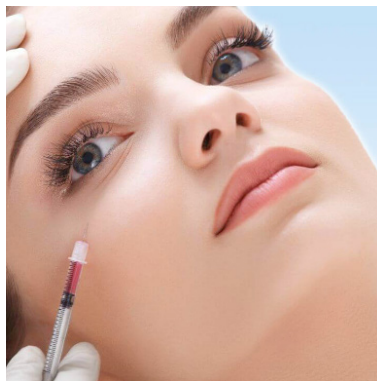

Keynote Forum March 11-12, 2019

Cosmetics 2019 & Biomarkers 2019



Joint Event
International Conference on
Plastic and Cosmetic Surgery
&
International Conference on
Biomarkers

March 11-12, 2019 | London, UK



Dario Rochira

The Private Clinic, UK

Dermo-adipose-glandular inferior flap versatility in mastopexy with and without implants: 6-years personal experience


In 1969 Dr. Liacyr Ribeiro used the inferior flap technique for the first time on a patient undergoing a breast reduction. Initially the inferior flap technique was described as “pediculo de seguridad”, an additional breast flap to use in an emergency if the surgeon removed too much breast tissue while performing a breast reduction. Its blood supply is guaranteed by the perforator vessels coming from the central lower pole of the breast. I use the inferior flap (a dermo-adipose-glandular flap) as an autologous local tissue which works like an implant-thus achieving a conical shape of the breast, fullness of the upper pole and long-lasting uplift. My own experience of performing the inferior flap technique on 190 consecutive patients over the course of 6 years in Italy and in the United Kingdom is presented and discussed. The procedure involves a vertical or T-inverted resection

pattern and the tailored inferior flap type 1 as described by L. Ribeiro in mastopexy with and without implants. The inferior flap technique is a safe and reliable technique for mastopexy with and without implant and for breast reduction when performed by well-experienced surgeons.

Speaker Biography

Dario Rochira is a highly experienced and respected UK cosmetic surgeon who has achieved an outstanding record of patient satisfaction, priding himself on achieving outstandingly natural surgical results for his patients. Qualifying in medicine in 2004, he has specialized in cosmetic surgery in particular since 2012 when he started his own successful private practice and is accredited with the UK General Medical Council sitting on their Plastic Surgery Specialist Register. He is the author of various scientific publications particularly on breast surgery and rhinoplasty and he frequently attends international meetings for lectures.

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 Notes:



Mireia Ruiz Castilla

Hospital Quironsalud Barcelona, Spain

Why and how to set up your robotic plastic surgery program?

The use of robotic surgery has grown exponentially during the last two decades in many surgical specialities. Since robots offer 100% tremor elimination and up to 5-to-1 motion scaling, robotic plastic surgery will allow the performance of minimally invasive procedures with the highest levels of precision. Some applications of robotic plastic surgery have already been described, and more are almost certain to emerge in the near future. However, robotic assisted surgery and microsurgery requires additional skills that need to be mastered and so specific training is mandatory. In this presentation, we highlight the importance of robotic assisted surgery in plastic surgery, focusing first on why a robotic plastic surgery program should be implemented and how it can improve our daily surgical practice. Secondly, we discuss

how it should be implemented in order to ensure that it is feasible, safe, and will improve patients' outcomes.

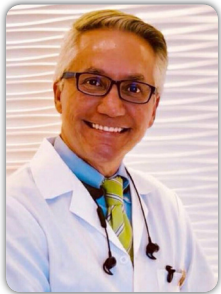
Speaker Biography

Mireia Ruiz Castilla is a recognized authority in Plastic, Cosmetic, and Reconstructive surgery. Qualified in Medicine in 2004, she is a board certified in Plastic, Reconstructive and Aesthetic Surgery since 2010 and PhD in surgery and morphological sciences in 2018. She worked as a Plastic Surgery consultant in Vall d'Hebron University Hospital and since 2017 she is the Head of Plastic, Reconstructive and Aesthetic Surgery Department of Hospital Quironsalud in Barcelona. She is a highly experienced surgeon in aesthetic facial and breast surgery, reconstructive surgery and microsurgery procedures. She has published several peer-reviewed articles in international journals and chapters in books, and she has presented several conferences. She is a member of the Spanish Society of Plastic, Reconstructive, and Cosmetic Surgery and the American Society of Plastic Surgeons.

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Notes:



Luis M Ayala

Fakih Medical Center, UAE

Liposculpture under local anesthesia, 21 years' experience

Giorgio Fisher from Italy was the 1st surgeon to perform localized fat removal in 1974. Doctors Illuoz and Fournier from France started modern liposuction in 1978. Dr. Klein from USA changed history with his tumescent solution in 1985. In 1996 I started performing liposculpture under local anesthesia to avoid risks related to general anesthesia. I have done 13181 cases since then. Before surgery patients get blood tests, garment, pictures are taken, BMI, consents. Day of surgery: in Miami and Caracas patients received oral sedation (midazolam syrup). In Dubai I use I/V sedation (midazolam). Infiltration solution that I use is in 1 liter of saline .9= 20cc of lidocaine 2% (400mg), 10cc. Sodium Bicarbonate 8.4% (84mg), 1cc of adrenaline. I use what I call "safe zone" with this formula: weight (Kg) X 55mg/Kg/400= Liters to infiltrate. For example if patient weighs 80kg it will be 80 x 55=4400mg of lidocaine max dose. If each litre has 400 mg of lidocaine this patient can receive up to 11 litres. The most frequent area is abdomen, waist, flanks, upper back (88%), thighs, arms, neck, knees (10%) and others (2%). Fat transfer has increased from 15% (1996-2006) to 85% (2006-2017). Most popular area to transfer fat=

Buttocks (83%), Face (12%), Hands (4%). Complications Major = None. Wound infection = 0.03%. Hyperchromia = 0.02%. Seroma = 0.0075%.

I explain to my patient that I'll do the 1st step (liposculpture) but diet and exercise are very important in order to have a great result. I have a wonderful team (anaesthesiologist, nutritionist, nurses, therapists and patient coordinators). Take pictures ("post-surgery amnesia"), keep patients inside the safe zone, keep record of patient's weight, I perform Lipo in a hospital and in a day surgical center (fully accredited)

Speaker Biography

Luis M Ayala has an extensive experience in plastic surgery more than 27 years. He is from Miami, USA, born in Venezuela and studied plastic, esthetics and reconstructive surgery from 1991-1994 in Paris, France where he received a summa cum laude distinction. His domain of expertise covers liposculpture using local anesthesia, facial, breast surgery, hair transplant, Botox, fillers. For him plastic surgery is an art. In 1996 he started doing liposculpture under local anesthesia in order to avoid risks related to general anesthesia. More than 13,000 cases prove that is the way to go to be safe and get great results. He works in Dubai UAE since 2017.

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Dario Rochira

The Private Clinic, UK

Preservation rhinoplasty: The purpose


Rhinoplasty techniques have changed dramatically over the last century. These techniques will always continue to revolutionise the way surgeons all over the world work. The Reduction Rhinoplasty concept introduced by Joseph has been widely used by most Rhinoplasty surgeons. Joseph's concept focuses on the dorsal height reduction to aid the removal of the dorsal hump. This method destroys the nasal keystone area resulting in aesthetic and functional reconstructive procedures. The dorsal preservation technique is suitable for around 60% of Rhinoplasty patients. By preserving the pre-existing nasal dorsum lines and nasal function, this innovative technique avoids many of the secondary deformities that often occur when the traditional reduction technique is used. By effectively utilising the "push down" or "let down" technique, popularized by Cottle and later by Saban the dorsum can remain preserved.

It is however with Baris Cakir that the Preservation Rhinoplasty concept reaches its full meaning. Cakir introduced the complete subpericondral/subperiosteal dissection of the nose. Thus associated with the push down or let down techniques leads to a minimal invasive approach, which features the Preservation Rhinoplasty.

Speaker Biography

Dario Rochira is a highly experienced and respected UK cosmetic surgeon who has achieved an outstanding record of patient satisfaction, priding himself on achieving outstandingly natural surgical results for his patients. Qualifying in medicine in 2004, he has specialized in cosmetic surgery in particular since 2012 when he started his own successful private practice and is accredited with the UK General Medical Council sitting on their Plastic Surgery Specialist Register. He is the author of various scientific publications particularly on breast surgery and rhinoplasty and he frequently attends international meetings for lectures.

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 Notes:



Radhashree Maitra

Yeshiva University, USA

Identification of biomarkers for precision management of metastatic colorectal cancer

Identification of novel prognostic and predictive biomarkers is purported to improve the classification and management of metastatic colorectal cancer (mCRC) and is the primary thrust of my research.


In this context we have identified a single nucleotide polymorphism (SNP) within DNA-repair enzyme O6-methylguanine DNA methyl-transferase (MGMT) by analyzing 78 mCRC patients. In a univariate analysis, patients with the TT genotype (12% of patients) had a median OS of 61.8 months, while those with homozygous GG or heterozygous GT had a median OS of 29.3 months ($P=0.06$). Further, in multivariate modeling, patients with the TT genotype had longer survival when compared to those with homozygous GG or heterozygous GT (HR 0.30; 95% CI:0.10-0.89, $P=0.03$), after adjusting for known clinical prognostic parameters such as gender, race, age at diagnosis, number of metastatic sites, number of chemotherapy lines received and CEA at diagnosis. The patients with the TT genotype had 70% reduced risk of death. We have also analyzed the expression of DNA excision repair protein ERCC-1 in 56 mCRC patients' pre and post oxaliplatin regimen by immunoblot and real time quantitative PCR. Median PFS was 190 and 237 days in the two groups respectively (log-rank test HR 2.35, CI 1.005-5.479; $p=0.0182$) Thus, increase in ERCC gene expression post platinum-based chemotherapy is a potential marker of drug resistance. Further in effort to understand the

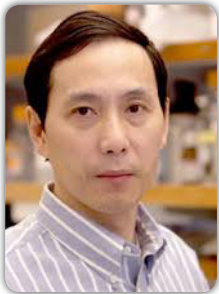
immune responses in mCRC we generated tissue microarray from 137 mCRC patients and performed immune histochemical staining for four different markers of B7 family of immune modulators. The analysis showed that increase expression of B7H3 is a potential biomarker of worse overall survival among patients of different racial origin. Race was designated as non-Hispanic white (NHW, $n=25$), non-Hispanic black (NHB, $n=63$), and Hispanic ($n=49$). Median survival was 747days for NHW and 565days for H patients ($p=0.036$, HR=1.6, 95% CI=1.03-2.58).

Speaker Biography

Radhashree Maitra is a Senior Scientist at Montefiore medical centre and also an associate professor of biology at Yeshiva University. She completed her bachelor's degree in chemistry (honours) with specialization in Biochemistry. She did her masters in Biochemistry with specialization in molecular Biology and also a Ph.D in Biophysics, molecular biology and genetics from Calcutta University in 1997. She qualified for UGC (University Grants commission, India) National Eligibility Test (NET) award in 1989 and then "Senior Research Fellowship" award from CSIR-INDIA in 1993. She did her first post-doctoral research at Washington University in St. Louis, Missouri and her second postdoctoral research at Albert Einstein College of Medicine of Yeshiva University, Bronx New York. She has around 28 original peers reviewed publications.

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 Notes:



Shaoguang Li

University of Massachusetts Medical School, USA

LTB4 as a biomarker for monitoring leukemia stem cells

Although a significant improvement was made in slowing cancer growth and progression during last several decades, the failure to eradicate cancer stem cells has become a major roadblock for curing some cancers. In general, to better understand how cancer stem cells survive and proliferate, it is critical to develop biomarkers for monitoring cancer stem cells during disease initiation, progression and treatment. In this study, we aim to develop leukotriene B4 (LTB4) as a novel biomarker for monitoring the presence and function of leukemia stem cells (LSCs) in chronic myeloid leukemia (CML) induced by the BCR-ABL oncogene. BCR-ABL tyrosine kinase inhibitors are effective in treating chronic phase CML but are unlikely to cure the disease as they do not eradicate LSCs. For developing curative therapeutic regimens for CML, a biomarker is needed for monitoring LSCs to evaluate the efficacy of new therapies. We have previously found that the arachidonate 5-lipoxygenase (5-LO) gene (Alox5) is a key survival-regulatory gene in LSCs (Chen et al. Nature Genetics 41:783-792, 2009). Because a known function of 5-LO (encoded by Alox5) is to

produce leukotrienes with leukotriene B4 (LTB4) as a major form, LTB4 may serve as a novel biomarker for monitoring LSCs in CML. Importantly, Alox5 is not required by normal hematopoietic stem cells, suggesting that LTB4 could be a specific biomarker for LSCs. It is worth pointing out that a method for monitoring LSCs in CML has not been developed, and LTB4 would be the first biomarker for monitoring LSCs. Here we intend to determine: 1) LTB4 is an indicator for the presence and function of LSCs; 2) LTB4 can be used for monitoring CML remission, relapse and response to an anti-LSC therapy and 3) LTB4 serves as a biomarker for indicating the presence and function of human CML stem cells.

Speaker Biography

Shaoguang Li obtained his PhD degree from Tulane University, USA. He did his postdoctoral studies at Harvard Medical School. He is currently a professor at University of Massachusetts Medical School, USA. He has published some seminal work related to leukemia stem cells in highly competitive journals such as Nature Genetics, JCI, PNAS, Blood, Leukemia, etc.

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