

# Once-Popular Technique Resurfaces for Face-Lifts

BY PATRICE WENDLING  
Chicago Bureau

PARIS — Add the curl lift technique to the growing list of so-called lunchtime face-lifts.

First popularized in the 1970s by René Guillemain, M.D., in Paris, the curl lift technique is being rediscovered, thanks to the use of a double-bevel needle like those used by upholsterers, according to Jean-Luc H. Vigneron, M.D., of the Centre Villabianca Dermatologie, Saint Paul de Vence, France.

The needle has two tips and a central eye that allow the surgeon to place stitches or long portions of threads subcutaneously, without an incision. The curl lift uses one loop of thread to lift selected parts of the face and a second loop of the same thread to anchor it to the more resistant tissues of the scalp, typically the galea. The procedure is done under local anesthetic, with little downtime, and leaves only a small scar in the scalp near the hairline.

"The future of the curl lift is clearly the lateral part of the neck," Dr. Vigneron told SKIN & ALLERGY NEWS. "My first five cases are really amazing."

The first line of polypropylene threads is placed in the upper subcutaneous layer. The needle is rotated 180 degrees and then moved upward in a second line parallel to the first. The 230-mm to 250-mm threads are knotted once the desired tension is obtained, then the knot is slipped 5 mm below the skin surface.

The main problem encountered using this technique is dimpling at the lifted area of the face, Dr. Vigneron said at the 4th International Academy of Cosmetic Dermatology World Congress. The dimples tend to disappear after 3 months, he said.

About 200 dermatologic and plastic surgeons have been trained in the curl lift technique in the



COURTESY DR. JEAN-LUC H. VIGNERON

**Dimpling is seen 8 days after a curl lift was done from the hair of the temple to the cheek.**

last year through the American Society of Aesthetics and Mesotherapy or the Vitality Institute, both of Miami Beach.

ASAM chair and president Abdala Kalil, M.D., said in an interview that he has performed more than 300 curl lifts in the last 2 years, and that dimpling occurred only once or twice when he first began. He has modified the technique to carry his institute's name, Vitality Lift, and said it offers dramatic, lasting results that are far superior to those seen with Aptos threads.

The Aptos threads or FeatherLift technique is more widely known in the United States and gained Food and Drug Administration approval in March 2005.

Both procedures take about 1 hour, require good vascularization in the skin, and are best suited to patients without heavy ptosis. ■

## LED Therapy Promotes Wound Healing

PARIS — Light-emitting diode phototherapy improves tissue quality and leads to accelerated wound healing after cosmetic and medical surgical procedures, Mario Trelles, M.D., reported at the Fourth International Academy of Cosmetic Dermatology World Congress.

Dr. Trelles uses combination light-emitting diode (LED) therapy with both near-infrared and visible red LED extremely narrowband (plus or minus 3- to 8-nm) arrays.

LED therapy promotes the anti-inflammatory process, activates blood circulation, and realigns collagen fibers. It reduces scabbing and erythema, without promoting keloids, he said.

Dr. Trelles is a pioneer of this application of LED energy. "It is not yet widespread because LED therapy is just at the beginning of its clinical practice, and like all 'new' therapies, it will take time to overcome the inherent 'conservatism' of many clinicians, particularly in the United States," Dr. Trelles told this newspaper.

In a series of 22 patients who underwent full face resurfacing and subsequent LED therapy, 12 patients experienced complete healing of facial tissue in 7 days, and the remaining 10 experienced complete healing in 9-11 days.

Several kinds of aesthetic procedures benefit from subsequent LED therapy, including surgical face-lifting, facial resurfacing, nonablative laser or

intense pulsed light skin rejuvenation, upper eyelid blepharoplasty, breast augmentation or reduction, and removal of abnormally pigmented or nonpigmented cutaneous lesions.

Results are less dramatic with diabetic ulcers or chronic ulcers caused by vascular conditions.

"All surgical wounds respond well, but in general the more extensive the wound, the better the response," said Dr. Trelles, a plastic surgeon with the Institut Mèdic Vilafortuny in Cambrils, Spain.

Dr. Trelles outlined his treatment protocol: a 633-nm wavelength treatment and an 833-nm treatment in the first week; three treatments at 830 nm in the second week; and one treatment at 633 nm in the third week, followed by a 1-month treatment-free rest period and a single treatment at 633 nm.

The 20-minute sessions deliver a radiant flux of approximately 96 J/cm<sup>2</sup> for the 633-nm head (Omnilux Revive), and 60 J/cm<sup>2</sup> for the 830-nm head (Omnilux Plus).

Postprocedural maintenance is not usually required if patients are compliant in using skin moisturizers and photoprotection, he said.

Dr. Trelles currently uses no pretreatment preparation of the skin, even with antiherpes medication. In more than 300 resurfacing cases, his rate of herpes infection was "virtually nil," he said.

—Patrice Wendling

## To Treat Hyperhidrosis, Consider Iontophoresis

BY TIMOTHY F. KIRN  
Sacramento Bureau

NAPLES, FLA. — Botulinum toxin may be a good treatment for primary focal hyperhidrosis, but for patients with hand or foot hyperhidrosis you should try iontophoresis first, Lewis P. Stolman, M.D., said at the annual meeting of the Florida Society of Dermatology and Dermatologic Surgery.

What you do not want to do for hyperhidrosis is refer patients for sympathectomy, he added, except as a very last resort.

The majority of patients who undergo sympathectomy for focal hyperhidrosis develop compensatory, and often severe, hyperhidrosis that can be more dispiriting and debilitating than their original condition, said Dr. Stolman of New Jersey Medical School, Newark.

"I don't think we as dermatologists should be referring patients for sympathectomy quite as quickly as we do," Dr. Stolman said.

Compensatory hyperhidrosis is an acknowledged consequence of sympathectomy, and in reported case series the incidence has ranged as high as 67%. In a recent review of reports, the incidence of compensatory hyperhidrosis in 22,000 patients was 52%.

For some patients, the compensatory hyperhidrosis is minor and localized to a limited area, and can be managed with botulinum toxin treatment. But it can also be much more severe, Dr. Stolman said.

Iontophoresis has a number of advantages over botulinum toxin, and may be equally effective, Dr. Stolman said. He was one of the early researchers in the use of iontophoresis for this condition but receives no money or grants from any manufacturer of iontophoresis equipment.

Botulinum toxin treatment has been reported to have an efficacy rate of 75%-95% for axillary hyperhidrosis. In his experience, 85%-90% of patients treated with iontophoresis for palmar or plantar hyperhidrosis have satisfactory improvement, and another 5% are improved when Robinul (glycopyrrolate) is added to the trays of water used for the technique, Dr. Stolman said.

Iontophoresis is probably less expensive than botulinum toxin. A 50-U botulinum toxin treatment costs at least \$250, and about half of patients will require two treatments to achieve good control. Medicare reim-

burses an iontophoresis treatment at \$24.69, and most patients need four to six treatments to achieve good control. Patients can also purchase their own equipment.

Two devices exist on the market. One costs \$150, the battery-operated Drionic device, and the other costs \$650, the Fischer MD-1a galvanic unit, which transforms alternating current to direct current. Though the devices are simple equipment, Dr. Stolman said he much prefers the more expensive device.

"The Drionic device in my opinion has given iontophoresis a bad rap because it is rarely effective," he said. "It is not the equal of the Fischer galvanic device in its efficacy, even though the literature may indicate that it is."

Moreover, unlike botulinum toxin, there is no chance of loss of any fine motor control with iontophoresis, Dr. Stolman added.

Most patients can treat themselves at home. The patient attaches the device's cathode to one tray of water and the anode to another tray, submerges their entire palms, one hand in each tray, and turns up the current to 15-18 mA for 10 minutes. Once patients have achieved control of their hyperhidrosis with four to six treatments, they repeat it whenever necessary, Dr. Stolman said. For some individuals that is every few weeks, and for others it is every week.

The sole drawback to iontophoresis is that it does not work well for axillary hyperhidrosis because it is difficult to attach the electrodes to the axillas, and many patients develop irritation.

The mechanism of action of iontophoresis is unclear, Dr. Stolman said. It may cause occlusion of the distal end of the sweat ducts by thickening the stratum corneum. It has been shown that when the stratum corneum in treated areas is stripped off with adhesive tape, the effect is reversed. Biopsy has shown no change in sweat gland structure.

An exciting recent development in the use of iontophoresis, Dr. Stolman said, is that it has now been shown that botulinum toxin can be added to the water trays, and is delivered effectively by the technique.

"Maybe we will find a way to get prolonged suppression of palmar hyperhidrosis for many months, as we do for the axillas, without painful injection," Dr. Stolman said. ■