



GUIDELINES

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- References—maximum of five
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- Figures/Tables—no more than two figures and/or one table

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Viewpoints

Successful Noninvasive Treatment of Festoons

Sir:

Among many changes that occur with aging, festoons present a unique challenge to the treating physician. Festoons are composed of lax skin and orbicularis muscle that hang between the medial and lateral canthi, and the pathophysiology is likely multifactorial; some of the proposed mechanisms suggest stretching of the orbitomalar ligament and lymphatic imbalance.¹ Many different surgical approaches—including microsuction, flaps, midface lift, and excisions—have been tried with variable success rates. These procedures are often complex, however, and can result in significant complications such as skin perforation, wound dehiscence, chemosis, and ectropion. Botulinum toxin, carbon dioxide lasers, chemical peels, cautery, and tetracycline injections have

been used as nonsurgical options, but the results have not been reliable.² Despite such efforts, treatment of festoons remains difficult and no standard treatment exists.^{3,4} Here we report a simple, noninvasive, and nonsurgical treatment method using microneedle radiofrequency technology to improve and possibly resolve festoons.

Two patients, a 56-year-old Caucasian woman (patient 1) and a 62-year-old Caucasian woman (patient 2), underwent treatments for their festoons with a fractionated radiofrequency microneedling device. The device (Infini; Lutronic, Inc., Goyang-si, Republic of Korea) consisted of 49 insulated microneedles (7 × 7 needles, 10 × 10 mm), whose tips delivered bipolar radiofrequency transmissions. Each treatment consisted of three passes, in which the depth of microneedles were set at 2.5 mm at 400 msec, 2.0 mm at 200 msec, and 1.5 mm at 100 msec, respectively. A topical anesthetic mixture of lidocaine 2.5% and prilocaine 2.5% was applied 15 minutes before the procedure.

Both patients noted a significant improvement of festoons after one treatment and were highly satisfied with the results. They tolerated the procedure well. The only side effect was erythema in the areas of treatment, which diminished over a few days and could be easily covered with makeup. Both patients opted to receive additional treatments, which resulted in additive benefits. Patient 1 has received two treatments (Fig. 1) over the course of 3 months and patient 2 has received five treatments over the course of 1 year. They have not experienced any scarring, infection, or recurrence from the treatments. As evident in Figure 1, the treatment also resulted in an overall rejuvenation of the lower lid complex.

Bipolar radiofrequency microneedle devices have been reported to improve periorbital wrinkles by increasing collagen and elastic fibers in the areas of treatment.⁵ Our two patients showed a significant clinical improvement of festoons, likely by means of a similar process of skin rejuvenation. Although we have not treated a large number of festoons with radiofrequency microneedling, this technique has been used many times successfully in our practice for other conditions such as acne scars and neck laxity. The procedure can be repeated 1 to 2 months apart as needed, and the ability to repeat the treatment is helpful given that festoons can recur even after surgical treatments.³ Future studies would be needed to further evaluate the efficacy and safety of the treatment. In summary, the ease of the treatment and the postprocedure recovery process make radiofrequency microneedling a promising treatment option for this challenging condition.

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Fig. 1. Patient before (left) and after (right) two radiofrequency microneedling treatments.

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PATIENT CONSENT

The patient provided written consent for the use of her images.

DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

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Is There Value to Seeing a Transgender Fellowship-Trained Surgeon?

Sir:

Is there value to seeing a transgender fellowship-trained surgeon? This question is one that is encountered with increasing frequency by patients seeking gender-affirming surgical care. An often-reported statistic is the prevalence of gender dysphoria worldwide, ranging between 0.5 and 1.4 percent.¹ By conservative measures, this equates to at least 25 million individuals worldwide that report and/or manifest dysphoria from gender incongruity. High-profile individuals such as Caitlyn Jenner have also increased societal awareness and recognition of gender dysphoria. This has resulted in an increase in transgender patients seeking care in a health care system that has historically been unaccommodating and insensitive to their needs.^{1,2} This deficit has turned into a unique opportunity for clinicians to proficiently serve this deserving population, but what should be considered proficient?

Resident education is regulated by the American College of Graduate Medical Education, the standard bearer for establishing and maintaining accreditation for the training environments of young physicians. This includes the fields of plastic surgery and urology (two of the specialties that most commonly perform gender-confirmation surgery). Still, substantial gaps in the clinical management and educational exposure to transgender patients exist in both fields. Multiple studies have shown that the average plastic surgery trainee receives only 1 hour of didactics and 2 hours of clinical exposure per year in transgender health.³ With the average training program ranging from 3 to 6 years, at best, that is only 18 hours of dedicated transgender exposure. Certainly, many