Why every cosmetic practitioner should be using the ATP approach


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Right from our undergraduate degree through to any postgraduate education that we undertake, we should always be putting our patient safety and results as being of paramount importance. We set out for a pleasant experience for our patients so that they keep coming back to see us, but also so that they tell their friends and family about us. And we all want to sleep well at night, knowing that we did the best that we could without worrying about the heath and safety of our patients. I am sure you are like me too. That is why I use the ATP approach, and why you should too. This is particularly important with cosmetic injectable procedures. So what is the ATP approach?

Anatomy.

When we first begin our education at university, we seemingly undertake anatomy wondering why we need to know it. It is only a little later on that you understand the relevance of that level of education. Then as you career progresses, sometimes we take it for granted that we learnt anatomy as we continue on in "auto-pilot" mode, doing what we have always done.

Whenever we learn a new skill, as well as hone our already established skillset, it is important that we always reflect back on the patient anatomy. After all that is what we are dealing with. This is particularly important when we are performing cosmetic injectable treatments.

When it comes to the face, there are four components of anatomy.

ANATOMY

Part one: Vertical fifths

The most balanced faces and results are when the vertical fifths of the face are of equal width. We look at this orthodontically, but we should also look at this when we are considering enhancement of the face. Asymmetry in one of the fifths will lead us to see that "something is not quite right", and we want to balance it out. The nasal alar should lie below the medial canthus of each eye for perfect balance. The most lateral fifth extends from the lateral helix of the ear to the lateral canthus of the eye. The next two fifths are represented by the eyes (medial canthus to lateral canthus). Of course there are racial and genetic variations to this "perfect" ideal of balanced fifths, but having some kind of reference helps us to identify where one fifth is wildly different to the other side.

Part two: Horizontal thirds

The face can also be divided horizontally into three parts. Before we define this, let's point out some important landmarks. The trichion is the hairline, and defines the most superior border of the face. The nasion is the bridge of the nose, and is the midline bone depression between the frontal bone and where the two nasal bones meet. The trichion and nasion define the borders of the upper horizontal third.

The next third runs from the nasion (or bridge of nose) to the sub-nasale, which is sub-nasal, as it's name suggests, is the point where the nasal columella joins the upper lip. So essentially the length of the nose makes up the middle horizontal third.

The lower third therefore runs from the sub-nasale to the menton, or the lowest point of the chin / mandibular symphysis.

Where one of the thirds is too short, we may consider orthodontic treatment, maxillofacial surgery or dermal filler to extend the third that is lacking. They are all equally valid, with proper discussion and consenting with the patient.

Part three: Depth of Anatomy

So now we have looked at the superficial components or surface anatomy, now we need to consider depth. Where is the deficiency for the patient? And when I am thinking about enhancing the deficiency, what structures are of importance in the area? An area that is a frequent concern for patients is the jawline area. Patients dislike the excess draping that occurs through life, where the jawline definition is lost. Indeed, it may have never been present in the case of a severe class II orthodontic malocclusion. So some options that we might present to the patient may again include orthodontics and maxillofacial surgery. But what options do we have that are non-surgical and present a short timeline for our patient. We have of course dermal fillers, where we can add to the jawline in key areas to improve both the projection of the chin in both the vertical and horizontal plane, but we can also add to the mandibular border and gonial angle. When we do this, it is vital that we reconcile the structures in the plane we are thinking of injecting.

If we remember back to the first year of anatomy back in dental school, we should recall that the facial artery passes over the mandibular border in the antegonial notch, which can be palpated by running your index finger along the jawline. So when we use dermal filler, it is so important that we avoid the facial artery. So how do we do this? We need to keep the dermal filler in the subcutaneous plane. Where the facial artery is deep, we must treat the patient superficially, and vice versa. We can use imaging devices such as laser guidance (which I love and use in my practice) or ultrasound. However ultrasound in particular has a steep learning curve and cannot be learnt in one day. Whilst useful where there are complications and in high-risk areas of the face, the use of ultrasound is certainly not the new standard, despite the misinformation that is sometimes spread by those with financial incentive to do so. I would recommend that you invest in studying an anatomy-based injecting course, to understand the areas of risk in the face. This is too important to ignore. You must know this when you inject. We understand this intimately when we undertake a local anaesthetic block. We must also recognise and appreciate the anatomy when you inject filler or toxin.

Part four: Movement

When I first studied cosmetic injectables, the dynamic movement of the face was not discussed at all. But as time has gone on, this is an area that is now recognised as being of high importance in the aesthetic zones. For this component of anatomy, we

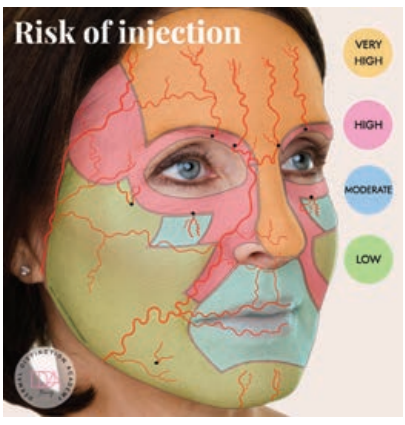
need to appreciate how the superficial and deep fat pads of the face move in relation to each other. Why? Because it will influence our dermal filler choice. If we recognise that the patient requires filler in the anterior cheek, for example, we often need to place dermal filler both superficially and in the deep fat pads too. And we will not use the same product in both. In the deep fat pad, which overlies the bone, the fat pad is fairly immobile on smiling and movement. In this area, we need to place a rigid filler, or one with a higher G-prime In the superficial fat pads of the face, the fat pads will re-drape on smiling, showing anger and sadness. So in the superficial fat pads, we need a filler that is resilient, that bends and stretches with the face, but also retains its original shape at rest. These fillers need to have resilient or dynamic bonds that move and stretch with the patient, resembling a lower Gprime product.

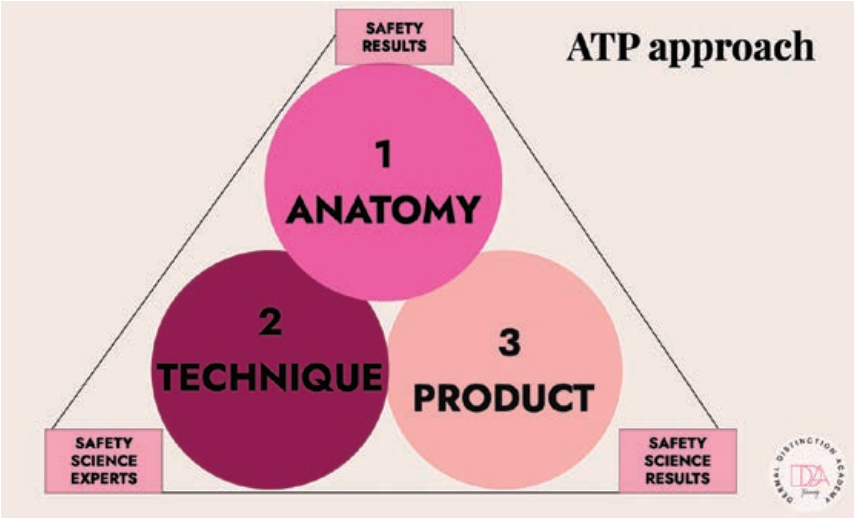
TECHNIQUE: Go Cannula!

In the scope of this article, we have now covered anatomy, so let's now turn our attention to technique.

To deliver the cosmetic injections, we have a number of options at our disposal. However we can broadly classify two approaches, which is the use of a needle and the use of a cannula. Most practitioners that know me, know that my preferred approach is the use of a cannula. The reason for this is improvement of safety for the patient. One of the major risks with dermal filler is the creation of a vascular occlusion, which is the result of dermal filler being accidentally injected into a vessel, causing the blood flow to slow or cease entirely. This will have devastating effects on the skin if not recognised and then rectified.

I was so fortunate to have an immensely valuable mentoring session in December 2022 with Dr Lee Walker, a global leader in cosmetic injectables and global KOL for Teoxane. He again reinforced my understanding and belief in the use of the cannula technique. Consider this: When we use a needle for dermal filler, the risk of a Vascular occlusion is 1: 6410. If you use a cannula, the risk of a vascular occlusion is 1:40000. No question, you need to master the cannula.





The other technique considerations are the style of deposition for the dermal filler that you are going to use. You may consider using micro-boluses, retrograde threads, fanning or tenting the filler through the tissues or any combination of the above. Consider the depth of tissue you are working in, the anatomy of the area, the product you are using, and then determine how the enhancement needs to be 'styled' to get the result you desire for your patient.

PRODUCT. The final tier of the ATP approach.

Having used many brands of dermal filler product over the years, I am so proud to use the Teoxane brand exclusively. I love that they have a product for every application, and that their dermal filler range offer both structure and resilient rheological properties that we all require as part of our armamentarium.

If we revisit the example of using a stiffer (high g-prime) filler for the deep fat pads of the anterior cheek, Teoxane has the perfect product for this, being the Teosyal Ultradeep filler. This has 25mg/ml of cross-linked Hyaluronic acid, with 10% degree of modification. The really great thing about this filler, is that each syringe has 1.2ml of filler in it, which is 20% more product than other available fillers on the Australian Market. This is a huge bonus to your results for your patient.

Then in the superficial tissues, we need a resilient hyaluronic acid filler, and Teoxane have the beautiful Teosyal RHA3 for this application. RHA3 has 3.6% degree of modification and 23mg/ml of HA included. Similarly, the RHA4 product can also be used in this plane. This product has a similar rheological profile, but has 1.2ml in the syringe. Again a 20% bonus for you and your patient. The perfect part of this equation, is that all the Teoxane fillers integrate very nicely in the layered structure that we place them in. We can most definitely not say this about using one brand of filler in one layer, and then using an alternate brand in another. We know in dentistry, that we cannot use one composite over a glass ionomer, for example, and get a strong or cohesive bond. It is the same in the cosmetic injectable dermal filler products. We should consider knowing a brand really well, and using compatible products together for better patient results, with a decreased risk.

I must disclose that I am an Australian Key Opinion leader for Teoxane. It is a great honour to have this recognition, but I do this proudly, knowing that the Teoxane brand is globally recognised as the best. My love affair with the brand started years ago, because it is important to me that the products I use are well tested, well tolerated and the best of the bst. It matters to me, and it should matter to every injecting practitioner. Know your product and the rheological product specifications. It determines your results.

The ATP approach is an all-inclusive thought and planning process for your cosmetic injections. By considering the four tiers of anatomy (vertical, horizontal, depth and movement), the techniques we are going to employ to deliver our result, and the product we are using, we give our patients predictable and safer results. The ATP approach is important so that we do not use protocol that is "paint-by-numbers" or done in a way that is not patient centric. Each patient needs to be considered as an individual and planned with the upmost of care and precision. ◆

To learn more about the ATP approach, please visit www.dermaldistinction.com