FROM THE PRESIDENT

It is my pleasure to introduce the inaugural ASCFS newsletter to our current and potential future membership. I see this newsletter as a foundational publication that will serve to both communicate the current activities of the organization as well as provide a forum for important scientific, educational, professional, and political issues of great import for our society. The newsletter will start off with two publications this year and my hope is that it will grow to a quarterly periodical in the near future. I would ask the membership to send me ideas and contributions so that the newsletter will become a vibrant interactive exchange that will be both informative and thought provoking. The ability of the newsletter to grow into an arena of scientific exchange is not out of the realm of possibility and will depend on both the leadership and membership going forward.

In this inaugural issue I have included articles on our most current boot camp run so ably by Davinder Singh and Stephen Beals, an update on our fellowships and data surrounding them spearheaded by Joe Williams, a look at CPT coding in our specialty and important initiatives of interest to the ASCFS by Drs. Golinko and Murthy, a report on Enhanced Recovery after Surgery (ERAS) by Jack Yu, a book review on “Facial Trauma” by Drs. Manson, Rodriguez, and Dorafshar written by one of our up and coming craniofacial surgeons and current craniofacial

(continued on page 2)
The state of our society is strong with an expanding membership, a fiscally sturdy financial position, an increase in the gravitas of our presence at the ACPA meeting with the Whitaker Lectureship and the Kawamoto Award, and a nicely developing relationship with the American Society of Pediatric Neurosurgery (ASPN). The state of our society is strong with an expanding membership, a fiscally sturdy financial position, an increase in the gravitas of our presence at the ACPA meeting with the Whitaker Lectureship and the Kawamoto Award, and a nicely developing relationship with the American Society of Pediatric Neurosurgery (ASPN). Mark Urata is working on another Joint Meeting with the ASPN in 2021 and I will communicate more information on that meeting as things become more concrete. Finally, I am so happy to announce that Ian Munro has accepted my invitation to be the Linton A. Whitaker Lecturer, at the ASCFS Annual Meeting which takes place during the American Cleft Palate – Craniofacial Association Annual Meeting, Friday April 3rd, 2020 in Portland, Oregon. Dr. Munro has been a luminary in craniofacial surgery but since retirement has rarely given any presentations or talks. I have fond memories, as a young trainee of Linton Whitaker and Henry Kawamoto, of watching the passionate repartee Dr. Munro and the other leading lights of craniofacial surgery at the time had at the meetings and the podiums during the question and answer periods, I and my contemporaries often wax nostalgic at those great debates! Portland should be magnificent!

I hope you will approve, enjoy, and participate in the evolution of this newsletter and I ask you to write me and let me know of any articles or issues you would like to contribute going forward, please feel free to write me at sbuchman@umich.edu. Most of all I would like to thank you for the honor of serving as your president I am grateful for the opportunity to lead this great organization.

Sincerely,

Steven R. Buchman MD, FACS
President ASCFS
M. Haskell Newman Professor in Plastic Surgery
Professor of Neurosurgery
Program Director, Craniofacial Surgery Fellowship
University of Michigan Medical School
Chief, Pediatric Plastic Surgery
CS Mott Childrens Hospital
Director, Craniofacial Anomalies Program
University of Michigan Medical Center

Watch your e-mail and the ASCFS website for details on the joint meeting with the American Society of Pediatric Neurosurgeons

January 24-27, 2021

Kapolei, Hawaii
The ASCFS wishes to recognize and celebrate the career of Dr. Joseph S. Gruss, who died from pancreatic cancer this June after a heroic battle with the disease. Joe was a long-term senior member of our society, and mentor to so many of us. His words of wisdom, whether said quietly over a beer, or loudly with his characteristic shake in his voice over a microphone, will be sorely missed. Our society and specialties are stronger from his time with us.

Joe Gruss was born in Johannesburg, South Africa on April 5th, 1945. After declining an opportunity to become a professional footballer, he completed his medical training and spent a year as a family doctor and casualty officer before moving to England for surgical training. In 1973, Joe moved to Toronto to train as a plastic surgeon. In his first faculty position at the University of Toronto, Gruss displayed his life-long passion and talent for facial reconstruction. Despite fierce early criticism and resistance, he introduced novel and controversial concepts of early bone grafting and fixation that are now the foundation of modern facial trauma surgery. Despite this, Gruss also saw the opportunity to take principles of facial trauma surgery and apply them to help children born in the Northwest with complex craniofacial deformities. He joined the Craniofacial team at Children’s Hospital and Regional Medical Center and fostered its rapid growth over the next 30 years into the current large interdisciplinary Seattle Children’s Hospital Craniofacial Center.

Never shying from what he felt was right, Gruss published pioneering papers on how to distinguish deformational plagiocephaly from lambdoid synostosis at a time when deformational cases were inadvertently undergoing unnecessary surgery. His dedication to team care of children born with cleft lip and palate earned him the Marlys C. Larson Chair at UW and he reveled in the opportunity to teach cleft care to developing teams around the world. He developed an international reputation for his fearless facial nerve sparing surgical approach to giant neurofibroma tumors of the face and neck. A tireless educator, Dr. Gruss gave more than 300 invited lectures, and founded the UW Craniofacial Surgery fellowship program 18 years ago that has graduated a long list of our ASCFS members. Although he received many prestigious career achievement awards, Joe Gruss always said his true honor was the opportunity to work with and get to know so many inspiring young patients as they faced their severe facial differences with courage and determination.

In January of this year, six months into his cancer treatment, Joe asked for his last celebration of craniofacial surgery in Seattle. Past fellows and colleagues from around the world joined him at the first Gruss Lectureship in Facial Reconstruction. Afterwards, he said that event was his true eulogy. Our Society will forever miss and thank our friend, pioneer and thought-leader, not just for his tremendous surgical skill and experience, but for the passion and heart he dedicated to moving our specialty forward.

In lieu of a memorial service, Dr. Gruss asked that friends and family continue his work advancing pediatric craniofacial surgery through donations to the Joseph S. Gruss Lectureship Fund https://giveto.seattlechildrens.org/gruss
Craniofacial Fellowships: Growth, Heartwood and A Call for Change

Our fellowships are extremely personalized, cloaked in tradition, a way of connecting our mentors to our students. We look at our programs as opportunities to solidify legacies and provide avenues to give back to our profession. Each fellowship is unique to its teacher and its institution. Yet all provide one thing, the single source of sustainability for our discipline.

We have grown! In the early 70’s a few scattered fellowships existed. Our most recent match had 29 programs formally participate. The early focus on surgeries of the facial skeleton has expanded and now include extensive training in cleft care, pediatric plastic surgery, ear reconstruction, facial reanimation, oculoplastic surgery and free tissue transfers. What began as a focus on the pediatric patient population now include adult facial trauma restoration, post-oncologic reconstruction and gender confirmation procedures. It has been a very rapid expansion. We have recognized the need to redefine ourselves and what we do. We have also increasingly found fellow physicians touting similar skill sets and official training banners obtained through routes far removed from us.

Here is one way to look at it. As trees grow a natural increase in the heartwood occurs. This is the part of the trunk that does not contribute to nutrition and sustainability but is important to maintain strength. The smaller sapwood component does the work of keeping the tree alive. As growth produces more branch junctions, opportunities for fungi and bugs to access the heartwood increase that can lead to weakening, splintering or death. The message is this: with growth, careful attention and examination must be given to keeping the tree healthy.

Over the last 10 years, 224 candidates have applied through our match program. During that period 21% of the programs (1/5) did not match a candidate. Seventeen percent of the candidates did not initially match into a program. In other words, in any given year 20% of our programs remain initially open and we have trained 188 fellows in the last decade (almost 19 graduates/year). It seems clear to many that there is a need to re-evaluate our training program structure.

Recently, program directors were asked specific questions on this topic. A 1-5 scale was used with 5 being the most favorable.

1. Does the current CF program structure needs to change – 4.1
2. Should we support an official sponsorship/certificate of the programs by the ASCFS – 4.1
3. An alignment of the programs under the ACGME – 1.7
4. An application process for new program requests – 4.1
5. Specific areas were found to be favorable for oversite including:
   a. Academic affiliation
   b. Core case requirements
   c. Common Educational Channels
   d. Database input
6. Program directors were ambivalent about post fellowship certifying exams and negative regarding site visits

Our Society initiated this dialogue by recognizing that complete uniformity in programs is not what we will find or even what we want. Our goal is that of inclusion but also some level of predictability and consistency in the end product. The initial action has been to ask all CF fellows to register their cases into the ASCFS database. By completing this task, the program will be certified (officially sponsored) by the ASCFS for the 2020 match.

As we begin to look closer at the data, we hope to provide a clearer landscape of what skillset our new colleagues carry with them into the community, stamped as a craniofacial surgeon. This goes to the core of our identity. Undoubtedly, the Society will need to redefine the relationship between itself and our training programs.

It is time for us to respond to our growth. It is time to look at meaningful change in our fellowship structure.

I am always open to conversation and ideas.

Joe Williams
Enhanced Recovery After Surgery (ERAS):
What is it, How to Develop and Implement it in Craniofacial Surgery

Taylor Chishom BS 1, Erika Simmerman Mabes DO 2, Jason Moraczewski BS 1 Jaclyn M. Yu, RN, MSN 3, Joseph Williams 4, Jack C Yu MD, DMD 1
1 Section of Plastic Surgery, Department of Surgery, Indiana University
2 Section of Plastic Surgery, Department of Surgery, Medical College of Georgia, Augusta University
3 Children’s Healthcare of Atlanta-Scottish Rite Hospital / 4 Children’s Center for Cleft and Craniofacial Disorders
Children’s Medical Office Building at Scottish Rite, Atlanta, Georgia

Enhanced Recovery After Surgery, or ERAS, is a standardized multimodal perioperative care program composed of evidence-based, data-driven care elements which starts from the moment the decision for surgery is made. A typical ERAS has four parts, called elements or phases: pre-hospital, pre-operative, intra-operative, post-operative. When used as automated bundled protocols, ERAS have repeatedly achieved significantly improved outcomes after surgery across geographical locations and surgical specialties. Efforts to improve surgical outcome are as old as the surgical profession itself. ERAS is different. First coined by the “ERAS study group” in London in 2001, the specific goal was to develop and implement standardized protocols or algorithms for optimal perioperative care based on evidence (Ljungqvist 2017). The participants then broadened the group, forming a medical society to continue improving perioperative care systematically. With the emergence of the nonprofit international medical society: The Enhanced Recovery After Surgery Society for Perioperative Care (the ERAS Society), this has expanded to a large network of over 50 leading centers around the world.

With documented outcome improvements, ERAS is gaining attention and acceptance worldwide. Centers implementing ERAS protocols are increasing at a rapid rate. As of 2019, there are fifteen specialties with established ERAS protocols including cardiac, colorectal, hepatobiliary, urologic, bariatric, head and neck, gynecologic, thoracic, transplant, and reconstructive breast surgery. While some are under development, there are very few published craniofacial ERAS protocols.

To develop the craniofacial ERAS protocols one must consider the following design goals. Foremost, it must have external validity: achieving same results in different centers by different teams. Surgical outcomes vary. Many factors cause these variations, some independent while others interact. In addition to variations in surgeons and patients, there are numerous differences in anesthesia support, hospital resources, intensive care capacities, even ambient microbial flora, and on and on at the local-regional levels. Despite all these, existing ERAS protocols have repeatedly produced impressive reduction in post-operative complications such as infections and anastomotic leaks, length of hospital stays, and 30-day readmissions.

The following are the five key steps in building craniofacial ERAS:

1. Collect existing multi-institutional protocols and long-term outcomes. Through detailed analysis of different outcomes and linking them to different treatments of similar conditions, an optimal protocol starts to emerge. This becomes the initial bundled order set or pathway.
2. Perform extensive literature search. This will not be easy as in just the last five years alone, Google Scholar contained 17,800 ERAS articles. To the extent possible, the key components of each ERAS must have statistically robust supporting data to justify their adoption. Such objective approach is critical as it avoids personalities and biases that are highly counter-productive yet common in every surgical specialties.
3. Solicit administrative and business supports. The goal of ERAS is, and should be, to improve patient care. If in so doing, healthcare facilities experience concomitant improvement in contributing margins, the protocol acceptance would be easier. The implementation becomes more difficult when the outcome improvements add extra facility costs producing negative net financial impacts. Early inclusion of the right personnel helps to alleviate or at least reduce such conflicts.
4. IT support. The output arm of majority of the ERAS protocol is in bundled pathways- predetermined order sets. Automated algorithms require programmers to convert the visions of anesthesiologists, surgeons, nurses, pharmacists, nutritionists, speech and occupational therapists into clicks in the EMR. The algorithm should contain a wide range of conditions (afferent) that trigger pre-determined countermeasures (efferent) to reduce the need for human inputs and variabilities. Simply stated, without IT, full ERAS will be very difficult if not impossible.
5. Repeated Iterations. Rarely, if ever, is the initial version of an ERAS perfect. Many, if not all protocols, require modifications to improve. Such improvements require outcome measures. The two important variables of this closed-loop system are the length of the monitoring periods and how to modify the protocol. It is easier to detect problems than to fix them. Changes that occur too frequently do not allow for detection of their full effects. Irrelevant or random modifications rarely produce the desired improvements. Too much or too many changes at any given time will obscure the individual effects.

Because of the importance of ERAS, on Friday April 12th, 2019, Dr. Steve Buchman, President of the ASCFS formed a taskforce to develop craniofacial ERAS. The members of this taskforce are: Craig Birgfeld, Jeff Fearon, Stacey Francis, Jesse Goldstein, Anand Kumar, Aaron Mason, Albert Oh, Alex Rottgers, Davinder Singh, Joe Williams.

Over the next several months, this Newsletter will release completed version 1.0 of the ERAS protocols.

Reference
The tenth annual ASCFS/ASMS Craniofacial Surgery Fellow Course, also known as “Bootcamp”, took place at Barrow Cleft and Craniofacial Center/Barrow Neurological Institute in Phoenix, AZ on August 2-3, 2019. It was co-hosted by Stephen Beals, MD and Davinder Singh, MD, who also served as faculty in addition to Steven Buchman, MD, Alessandro Cusano, MD, Chris Forrest, MD, Amanda Gosman, MD, and Alex Lin, MD. Thirty fellows attended the course, which consisted of a two day program with lectures followed by cadaver lab dissection for all major craniofacial osteotomies, skull base exposure, and facial nerve dissection. Small groups were held over lunch to promote clinical discussions and case reviews. All participants were invited to enjoy social events on both evenings to get an opportunity to interact with one another and faculty. The ASCFS gifted the fellows with the new Craniofacial Atlas to begin their careers as Craniofacial Surgeons. KLS Martin and Stryker provided equipment for the lab, and KLS Martin supported the course. The course will be held again on August 7-8, 2020.
Foundations of Ethics in Craniofacial Surgery

Christian J. Vercler, MD, MA

Ethics is disciplined reflection on moral ambiguities. While studying theology in graduate school, I was a research assistant at the Center for Applied Christian Ethics at Wheaton College. Ethics in that context was relatively straightforward. We would try to solve a moral dilemma by studying the tenets, principles, and teachings derived from 2,000 years of Christian writings, traditions, and practices and arguing about how they might apply to the dilemma. Needless to say that in my role as chair of the ethics committee at the University of Michigan, when I am called to help solve ethical dilemmas at the bedside that is not the approach I use. We live in a pluralistic society, where there is no state sanctioned religion, nor universal worldview that we all share. Ethical dilemmas stem from a conflict in values, not facts, so while we celebrate this diversity, the lack of consensus about the meaning and purpose of life can lead to a conflict in the prioritization of values. For example, a good utilitarian pursues the greatest good for the greatest number and so can justify turning over an innocent man to the angry mob to prevent the mob from burning the village. A devoted follower of Immanuel Kant’s theories could never justify that action, as she would prioritize the value of the individual person and think about her actions related to building a just society. It is clear that different worldviews and frameworks lead to different conclusions about what is right and wrong.

In the late 1970s a philosopher and a religious studies professor, Beauchamp and Childress (respectively) put together a book that has defined our discourse about ethical dilemmas ever since. Their book, Principles of Biomedical Ethics’ proposed a set of mid-level principles that do not rely on buying-in to an overarching philosophical or theological framework in order to be useful. The principles of beneficence, non-maleficence, respect for autonomy, and justice are now familiar to anyone who graduated from medical school since the 1980s. The idea is that these principles should guide our interactions with our patients and that when we are faced with what we experience as an ethical dilemma it is because the duty to follow one principle conflicts with the another principle. A classic example is when a patient is refusing an operation that you know will benefit them—a clash between respect for autonomy and beneficence. Solving the dilemma involves further specification of the duty to uphold each of the principles and a deeper investigation into the details and context of the situation. Is the refusal of the operation an informed one? Is the patient making a decision based on a misunderstanding, misperception, or unreasonable fear about the operation? Is there something about the situation where the patient’s decision-making capacity is hindered in a way that could be restored by the operation (e.g. a patient getting septic from an infection that requires operative debridement?) This type of discourse is illuminating and can be very helpful in navigating tough decisions, but it cannot escape relying on more foundational commitments to prioritize values within the principles. For example, when faced with a refusal of care a Libertarian would value the “right to be let alone” (as Justice Brandeis called it) very differently than one of Mother Theresa’s Sisters of Mercy, and so each would come to different conclusions about the appropriate course of action.

Is there a point of view that we can all agree upon? It seems nearly impossible in our current political climate. However, I propose that we craniofacial surgeons do have something that unites us all and that serves as the foundation of our ethical commitments. We have the patient-surgeon relationship, which I argue is a unique relationship vis-à-vis all other human relationships, and we have the community of craniofacial surgeons to hold one another accountable to fidelity to that relationship.

Edmund Pellegrino, a physician and giant in the field of bioethics, was the first to extensively develop the idea that our ethics should be built upon the doctor-patient relationship. He noted that the very fact of illness, which brings patients to us in a disadvantaged state seeking help, is met by the act of the medical profession, which is to rise to meet the patient where they are and to prioritize their needs over our own. This relationship is intensified within the patient-surgeon relationship. As surgeons we wield an immense amount of power. We command both knowledge and a skill set that are not held by other surgeons, let alone by our patients. Many of our patients are minors, which further heightens the unbridgeable chasm of knowledge between us and our patients. Informed consent is often considered the core event that changes our “assault” of the patient into a morally licit action, but do we really think that anyone consenting to rigid external distraction has a good understanding of what their child is about to go through? There is a one-sidedness to the interaction as well. The patient can never know us in the same way we know them. An operation is a major life event for the patient and family, one that leaves psychological, emotional, and physical scars, but to us it is part of routine.

The appropriate response to these insights about the special relationship between patient and surgeon is to understand the relationship not just as a contract, i.e. an exchange of services for a fee, but as a covenant. The concept of a covenantal

---

We have the patient-surgeon relationship, which I argue is a unique relationship vis-à-vis all other human relationships, and we have the community of craniofacial surgeons to hold one another accountable to fidelity to that relationship.

(continued on next page)
relationship is certainly antiquated, but it captures the reality of the association. The two parties in a covenant are not on equal footing. It must be fiduciary. The individual in a position of greater power promises to put the welfare of the other ahead of his or her own interests. Understanding the situation this way begins to help one prioritize values, and provides content to the discourse that occurs when ethical dilemmas occur.

Ours is a real community, whose boundaries we defend. We have a common origin story and common lineage. If you cannot trace your training back to Paul Tessier, it’s highly unlikely you are accepted in our midst. One of the hallmarks of a profession is the members of that profession holding one another accountable to the high professional standard of the group. Any casual observer of a meeting of craniofacial surgeons would report that we constantly question and challenge one another, arguing over the best approach to take care of the difficult problems we face with our patients. It is within this context that we can and should openly debate and discuss the ethical issues we encounter, such as: When does innovative surgery become unregulated research? What is my responsibility to the patient who had a botched operation performed by a non-craniofacial surgeon? What is the proper approach to surgical mission trips and should we set formal guidelines about who should get to do it?

The point is that despite the difference between a monotheist, polytheist, atheist, Texan, or communitarian, all can draw on the relationship that we share with our patients. It is this unique human encounter that entails certain responsibilities on our part that can help us prioritize values when engaging in discussions about the “right thing to do.” These discussions are best done within the community of craniofacial surgeons, so stop me at the next meeting and let’s talk about some hard ethical problems. Together we can engage in some disciplined reflection on moral ambiguities.

Endnotes

FROM THE ISCFS 18th International Congress September 16-19, Paris
The ASCFS Foundation

The Kawamoto Best Paper Award
Several years ago, the ASCFS began a tradition of recognizing outstanding craniofacial papers presented during the annual meeting. An annual Best Paper Award, was named in honor of Henry Kawamoto, a founding father of the organization and leader in craniofacial surgery. The Kawamoto Best Paper Award provides recognition for the best craniofacial paper presented at the ASCFS annual meeting.

View Past Recipients

Donate to the Kawamoto Fund

The J.G. McCarthy Visiting Scholar Award
The award will provide a stipend of $1,500 award to support the recipient to visit a craniofacial center of their choice during their first year of practice, with the purpose of expanding their appreciation of craniofacial surgery. The award will be granted to the applicant who best demonstrates these personal qualities with the goal to use their talents in the pursuit of excellence in academic craniofacial surgery.

The ASCFS Board welcomes applications from current ASCFS fellows. To apply, please send your CV and a letter describing how the use of this award would contribute to your career in craniofacial surgery to Lorraine O’Grady before July 31st.

Apply Now
Career Summary
Donate to the McCarthy Fund

The Linton A. Whitaker Lecture
Given during the ASCFS Annual Meeting, the Lecturer is given by a person whose work or career exemplifies the very best in the art and science of craniofacial surgery. Dr. Whitaker had a distinguished career as a master clinician, educator and researcher, which spanned over four decades at the University of Pennsylvania and at the Children’s Hospital of Philadelphia. Stemming from his time spent with Paul Tessier, he was responsible for introducing craniofacial surgery to North America along with Ken Salyer, Fernando Ortiz Monasterio, Ian Munro, Ian Jackson, Henry Kawamoto and Tony Wolfe. Along with these other giants of craniofacial surgery, he founded the premier organization within craniofacial surgery, the International Society of Craniofacial Surgery.

View Past Recipients

Career Summary
Donate to the Whitaker Fund

ASCFS Foundation
The American Society of Craniofacial Surgery (ASCFS) created the ASCFS Foundation to serve as the education, research and philanthropic arm of the organization. The mission of the Foundation is to improve the quality of life of craniofacial patients through education, research and development.

The Foundation will accomplish its mission by supporting education and research through grant and award programs, including lectureships and research scholarships. We hope that you will consider a donation to the ASCFS Foundation. You may select to give to the general Foundation Fund or you may support one of the current initiatives, created to honor the esteemed founders of the specialty.

Donate Today

If you wish to make a contribution to more than one fund, please proceed here:

Donate to Multiple
Reimbursement for craniofacial operations is intimately tied to work-relative value units (WRVUs). The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association which describes surgical services and is designed to communicate uniform information about procedures among surgeons. As the intricacy and complexity of craniofacial surgery increases, many members note that the CPT codes have not evolved to keep pace. In an effort to increase awareness and agreement of appropriate CPT coding within craniofacial surgery, it would be in the interest of our Society to voice recommendations.

From personal conversations, the authors note large variation within coding for procedures such as cranial vault procedures with named CPT codes to procedures like mandibular distraction where there are no assigned CPT codes. Moreover, many ancillary procedures are now expected and included in the correction of craniofacial deformities; but not expected or included in the description of the CPT code assigned to the procedure. More precise CPT codes for craniofacial procedures will yield multiple benefits, including improved reimbursement, better communication amongst clinicians. As more national databases are mined to reveal outcomes of large cohorts, accurate CPT coding would lead to better outcomes research as well.

Closely related to procedural codes are the ICD-diagnostic codes. ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). Approximately 27 countries use ICD-10 for reimbursement and resource allocation in their health system, and the US utilizes its own national variant. In spite of recent expansion of the coding system from the ICD-9 to ICD-10 to better accommodate clinical accuracy and specificity, almost no changes occurred in the craniofacial codes. Most notably, only one ICD-10 code exists for every sutural type of craniosynostosis. Obviously having more accurate codes would allow for appropriate data collection, clearer documentation, and more accurate claims processing.

A recent letter to the Editor of Child's Nervous System cited results of a national survey of craniofacial surgeons and pediatric neurosurgeons. Of the respondent group, the majority of craniofacial plastic surgeons (76%) and pediatric neurosurgeons (86%) agreed that it would be valuable to design ICD codes that reflected the specific suture involved in craniosynostosis rather than head shape (e.g. trigonocephaly). Over 95% of those surveyed agreed that there needs to be a more adequate classification system, rather than the collective diagnosis of craniosynostosis, (ICD-10 Q75.0).

The authors propose a task-force of interested members of the Society in order to spear-head efforts and advocate the Society’s voice with the American Medical Association and WHO. In addition, development of an online portal, would provide for consistency in diagnostic and procedural coding. This would allow for a navigation through difficult scenarios or coding concerns for craniofacial surgeons.

If interested in becoming part of the solution, please contact Dr. Steven Buchman, Dr. Ananth Murthy (amurthy@akronchildrens.org) or Dr. Michael Golinko (Michael.golinko@vumc.org).

References:

2. Gonzalez SR, Han A, Golinko MS. Shifting epidemiology of single-suture craniosynostosis and the need for a more granular ICD classification system: a national survey of members from the American Society of Pediatric Neurosurgeons (ASPN) and the American Society of Craniofacial Surgeons (ASCFS). Childs Nerv Syst. 2019 Jun 1 [Epub ahead of print]
Book Review: Facial Trauma Surgery: From Primary Repair to Reconstruction

Reviewed by Kavitha Ranganathan MD

As summer comes to a close, we are promptly ushered into the open arms of fall, a season defined by the start of a new academic year and fresh-faced trainees eager to embark on the journey of what it takes to become a plastic surgeon. Faculty begin preparing for a new series of interviews during which time they must convince medical students that their program is the next best thing, and we begin to question what it takes to actually become well-trained. In plastic surgery, this is most easily defined as the ability to gain exposure to all facets of both aesthetic and reconstructive surgery under the mentorship of clinicians with sound judgement and technical aptitude. Confounding this definition, however, is access. Just as care for our patients is governed by access, achieving broad-based training in plastic surgery is similarly limited. The ability to access a comprehensive case load in a patient population that requires the breadth of operations that we as plastic surgeons can offer is variable. This is no more true in any branch of plastic surgery than it is in craniofacial surgery, and particularly with regards to craniofacial trauma. As the epidemiology of facial trauma is heavily affected by geographic, economic, and patient demographic factors, exposure to these cases is highly institution dependent. Therefore, while some trainees will exude comfort and confidence with any facial trauma case by the end of residency, others will inevitably dread the impending mandible fracture that will come in while on call as a new attending; those of you reading this feature now may still experience those jittery feelings of dread and doom as you reflect upon your own training and comfort with complex facial trauma. The utility of textbooks and educational resources in this particular setting must not be underestimated; in fact such resources may be the only point of reference available in preparation for such cases depending on one’s depth and breadth of training.

“Facial Trauma” by Drs. Manson, Rodriguez, and Dorafshar is to craniofacial trauma as the original textbook by Grabb and Smith is to general plastic surgery. Written with the needs of young plastic surgeons and trainees in mind, “Facial Trauma” delves into the principles upon which facial trauma reconstruction and repair were founded. Each chapter is structured in a similar fashion beginning with background information and context, indications for surgical intervention, pre- and post-operative management, and concluding with a discussion of complications. The book is structured into three sections: 1. Primary Injury, 2. Pediatric Facial Injuries, and 3. Secondary Reconstruction and Restoration. The “Primary Injury” section is further divided into twenty-one chapters focused on each anatomic facial fracture pattern ranging from temporal bone fractures to mandible fractures to panfacial fractures. The second section is divided into five chapters based on the most common anatomic fracture patterns in children. Section 3 is composed of seventeen chapters, and serves as an introduction to secondary reconstruction in facial trauma patients; the strategies and approaches documented in these chapters serves as a vital resource for anyone caring with residual defects after trauma. While photos and videos of patient case examples give the reader the opportunity to apply the principles discussed in each chapter, the clear anatomic illustrations at the beginning of each chapter are of most value to the intended audience of each section. Although specific operative steps regarding exposure and fixation are not the focus of this text, trainees can concomitantly utilize Ellis and Zide’s text “Surgical Approaches to the Facial Skeleton,” to adequately prepare for cases.

Although evident that the book was written with the needs of younger trainees in mind, there are also sections throughout the text, particularly with regards to Section 3 on Secondary Reconstruction and Restoration, that are relevant to more experienced facial trauma surgeons. For example, while many plastic surgeons care for patients with condylar fractures of the mandible, very few treat complications related to the temporomandibular joint; a chapter dedicated to alloplastic and autologous temporomandibular joint reconstruction effectively introduces the topic in this text. Similar introductory chapters to virtual surgical planning, secondary nerve reconstruction, and dental rehabilitation are included for more experienced practitioners.

There are two specific aspects of this text that distinguish it from others of its kind. First, Appendix 1 is the hidden gem of this text. Appendix 1 consists of evidence-based summaries regarding questions important to facial trauma reconstruction. The authors begin by posing a clinical question, and subsequently make recommendations after examining and presenting the literature relevant to the study question. This section in particular serves as a critical resource for both clinicians and researchers interested in furthering the field of trauma reconstruction as tables and summaries of published evidence regarding the timing of orbital reconstruction, use of antibiotics, method of mandible angle and condyle fracture fixation, and more are found in this section. Second, to the benefit of anyone at any level of training, Dr. Manson’s personalized documentation of his approaches, preferences, and lessons learned at the end of each chapter serves as a brief summary rooted in extensive experience and expertise. When read carefully, Dr. Manson’s excerpts serve as an ode to the aspects of craniofacial trauma that deserve celebration or as words of warning to those areas that we must continue to challenge. For those from programs that lack significant training or mentorship in facial trauma reconstruction, these tips and tricks in the written word serve as a valuable substitute. So, as Dr. Manson himself says, “…read on, enjoy, and benefit from the mastery of experienced practitioners who are ready to assist you with these difficult problems.”
CAPPSKIDS: Ethical Concerns with Paid Membership

CAPPs (Craniosynostosis and Positional Plagiocephaly Support) was established by parents in 1999 as a small internet chat group and has now grown into a larger organization. The organization is directed by a mother who had a child with craniosynostosis with a background in Business Management. They aim to support and educate families diagnosed with craniosynostosis. Their goal is to assist with consultations to hospitals that have an established relationship with CAPPS. The organization urges families to obtain a second opinion via their self-pay program online or directly with preferred providers. The self-pay second opinion/consult portal program aims at overcoming barriers to families having limited access to highly specialized care. This online referral system allows families to obtain a second opinion regardless of their ability to travel. However, it requires a referral from their PCP if the family resides in a different state from the CAPPS preferred specialist. Concerns have been raised as the rational for the decision to which providers the family see as a second opinion is unknown; is it based on geography or to particular CAPPS “preferred providers”?

Additional ethical concerns are raised with this organization, as paid membership is required to be listed as a specialist on CAPPS. It is unclear when CAPPS started to offer membership services for craniofacial teams and exposure on the website is based on multiple tiers of membership. Memberships range from $300 per month for individual surgeons to either $400 or $500 per month for team listings (Basic or Premium). There are additional costs for other benefits: banner add ($300-$5500/year), promotion of your team in an additional state ($500/state), advertise articles on CAPPS ($99 each) and more. The advertising guidelines based on the code of ethics from the American Society of Plastic Surgeons notes the following:

“A Member shall not compensate or give anything of value directly or indirectly to a representative of the press, radio, television, or other public communication media in anticipation of or return for recommending the member’s services.”

It is anticipated that more groups like CAPPS will form that require paid membership for physicians in return for patient referrals. It is important for ASCFS to be the resource for families and partner with support groups to provide accurate information without the need for paid subscriptions. Providers should be cautious with paid advertising; it is our duty as an organization to regulate and be unified.