

## Cutaneous and Aesthetic Surgery in the New Millennium

During the last decade, the specialty of the cutaneous surgery has evolved rapidly. This is unprecedented and is driven by technological advances in response to rising demands. Perhaps no other branch of medicine has seen such a rapid progress during this period. For example, the cancer-associated mortality has only marginally improved over last 50 years.<sup>[1]</sup> The management of diabetes remains largely dependent on oral hypoglycemic agents and injectable insulin. In contrast, modern treatment options have dramatically changed the practice of aesthetic medicine and surgery. Cutaneous and aesthetic surgery has become more popular, less invasive, less painful, more efficacious, and safer than ever before [Table 1]. Management of wrinkles and folds with hyaluronic acid fillers is a popular minimally invasive cosmetic procedure. Treatment modalities which stimulate synthesis of new collagen can reverse the aging-related changes, and artificial and natural substances can restore the volume of the face. Different types of lasers and lights have provided convenient treatment options to patients and surgeons, with many of them have little or no downtime. Vascular lesions can be treated with less painful and noninvasive pulse dye laser. Resurfacing options are widely available and practiced. Fractional laser technology has revolutionized resurfacing options. Dermal pigmentation may be improved with Q-switched lasers. Botulinium toxin makes wrinkles disappear in an aging face. Radiofrequency surgery has provided more effective and less traumatic treatment option for both therapeutic and cosmetic indications.<sup>[2]</sup>

However, many challenges remain – diseases such as keloids do not have a satisfactory treatment and have

been ignored by industry and researchers alike. We do not fully understand the pathogenesis of nonmelanoma skin cancers. Botulinium toxin and fillers are at best a temporary solution for an aging face. Hair reduction can be achieved with lasers, but often patients require regular sessions to maintain the effect. Not all patients with dermal pigmentation respond to Q-switched laser and diseases such as melasma frequently recur. Hemangiomas and lymphangiomas may still require radical surgery. The utility of follicular unit transplantation is limited

**Table 1: Cutaneous and aesthetic surgery in 1980s and 1990s and the new millennium**

Problem	Cutaneous surgery in 1980s and/or 1990s	Cutaneous surgery in the new millennium
Unwanted hair growth	Electrolysis — more painful, invasive, time consuming, and associated with scarring	Laser hair reduction — less painful, noninvasive, and not associated with scarring
Wrinkles	Jassener's peel — associated with long downtime, more pigmentary changes, unsuitable for skin of color. Bovine collagen-based fillers- had high risk of allergic reactions, lasted only few months	Botulinium toxin and hyaluronic acid fillers — safer, less allergenic
Aging face	Facelift — more invasive, technically demanding.	Laser resurfacing, fractional technology, radiofrequency technology — less downtime with nonablative procedure
Benign growths	Electrosurgery — more collateral damage, cruder technique	High frequency radiosurgery — less collateral damage, better scar
Scars	Cold knife scar revision — Z-plasty, W-plasty- required more skills, more invasive	Laser remodeling/ resurfacing— less invasive, requires less skill
Unwanted fat	Tumescence liposuction — more invasive, did not take care of skin laxity	Noninvasive ultrasonographic and invasive radiofrequency assisted liposculpture — takes care of skin laxity
Baldness	Punch grafting — poor cosmetic outcome	Follicular unit transplantation, follicular unit extraction — better cosmetic outcome
Vitiligo	Punch grafting and suction blister grafting — crude methods, difficult to cover large areas, less aesthetic results	Cell suspension transplantation — easier, can cover large area in quick time, natural color

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by the availability of donor area.<sup>[3]</sup> Liposuction is not a cure for obesity.

In this changed scenario, many industry-driven, empirical, and ineffective procedures have emerged and are being used in spite of little or no evidence of their efficacy. Journal of Cutaneous and Aesthetic Surgery (JCAS) aims to provide scientific and evidence-based knowledge to its readers. We invite papers with new ideas and innovations in the field, however with caution. All such papers go through critical review process and scrutiny.

The editorial board has tried to keep a balance between aesthetic and therapeutic cutaneous surgery. The aim is to cater to the needs of different but related specialists such as Dermatologic Surgeons, Aesthetic Surgeons, Maxillo-facial Surgeons, Plastic Surgeons, and Reconstructive Surgeons.

Current acceptance rate in JCAS is less than 50%. This

shows the rising popularity of this journal. The journal receives a large number of submissions to choose from. With this, readers can expect more quality papers.

JCAS is the only Open Access journal in this field and we do not charge authors for publishing their papers. Therefore, we largely depend for our expenses on institutional subscriptions and industry support. We will continue to offer the journal for free in foreseeable future.

I hope you enjoy reading this issue. Please spare time to send your feedback and suggestion at editor@jcasonline.com.

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