Dealing with injectable complications

The *Expert Consensus on Complications of Botulinum Toxin and Dermal Filler Treatment, second edition*was created by a group of UK practitioners headed by Mr Christopher Inglefield. Mr Inglefield outlines the motivations and aims for creating guidelines and Marie Duckett offers her advice on the vital role of managing patient expectations in order to avoid complications

Mr Chris Inglefield: Our group came together following a Merz Aesthetics Partnership in Practice Conference, because we realised there was a lot of discussion about managing complications in toxins and fillers, but there was very little good data putting it all together. So we gathered a diverse group of individuals with some 25-30 years of experience in the aesthetics industry, bringing in as many experts as we could and putting it all together. We looked at why we need an expert consensus on this, who should be on this expert panel, the development of the consensus document, and then divided it into two sections, one: recognising and minimising complications, and two: complications and risk reduction.

We all know that a lot of consumers are interested in this industry, otherwise we wouldn't be here—and it's an industry that's rapidly growing. Most of the adverse events that we see are short-term complications, especially with toxins and the use of HA fillers. Even some of the more disastrous complications with fillers can be dealt with quite successfully. What was evident to us from the outset was that there wasn't a good consensus on how to manage specific complications, which would act as a guide for new practitioners, as well as for experienced practitioners that come across the more unusual complications. So, creating that became our goal. Jenny Brown was our medical writer who brought us all together—she got us all in line and helped to ensure we were all doing the right thing.

The project was started in May 2013. We agreed to focus on non-permanent fillers, which are most commonly used in practice – hyaluronic acid, calcium hydroxyapatite, and poly-L-lactic acid, and we all contributed, depending on our areas of expertise. In the part one section it's recognising and minimising complications. We looked at each area of the face, suggested toxin injection points and dosing; for fillers, looking at the different viscosities and why you should use a particular product in a specific area to deal with specific problems, because understanding the product is very important to avoiding complications. We looked at potential complications at each area, each site, and then recommended steps by reviewing the published evidence, and also taking into account our various experiences of how to minimise the complications.

Part two was looking at complications in general and how you reduce complications in your practice on a very practical level. We looked at dealing with patients—how do you look at that patient and then suggest a lip treatment, or a temple treatment, or a non-surgical nose treatment. We considered how we approach that patient to absolutely minimise the risk—we know we can't eradicate, but we need to be able to minimise risks as much as possible. The significant complications of vascular compromise, infections, are well covered in the document. In the second edition we've added in a section on the use of hyaluronidase, which is extremely helpful. In the recommendations, we talk about the dosing for the use of hyaluronidase, how you can use it to refine your treatment and, much more importantly, in the emergency situation how you should use hyaluronidase in managing vascular compromise.

Marie Duckett: Managing patient expectations is probably one of the simplest and easiest ways of ending up with a happy patient at the end of the treatment experience. The consultation is the key. If you haven't done a thorough consultation you will never establish exactly what your patient understands of what may happen, what can happen and what can't happen. A pre-treatment facial assessment is an absolute necessity. Without that, you will find that you'll end up with patients who

expect to be able to walk out with a pair of Angelina Jolie lips when they have a small heart-shaped face that really wouldn't be able to accommodate lips of that size, nor do they have the dental structure underneath, nor the bony structure to support such lips.

Pre-treatment photographs are comforting for clinicians, but more importantly are a good baseline for the patient to remember what they did look like. In my experience, patients suffer a degree of amnesia, which is selective when they have a treatment. If you haven't established your baseline by having good pre-treatment photographs patients can often come back and say that they feel that they didn't have an adequate treatment, or they have a line where they didn't have a line before. Another essential is setting out the treatment plan. Make sure that not only do you have a copy of the written treatment plan, but also that the patient goes away with a copy of their written treatment plan so that they can refer to it and know exactly what you did and what you intend to do at further treatments. Most important of course is that you have your written patient consent, and you should document that, the fact that you've taken that, in the notes. The consent form these days has become much more wordy, much more complicated, and certainly the difference, when I look back through old patient notes of people I've been treating for the last 17, 18 years, the consent form 17, 18 years ago was just about two paragraphs, and now the actual written consent can be several pages, including things that I never expected to see on a consent form, like blindness.

When dealing with patient expectations, I experienced several different types of patient. You have the normal patient who will listen to you and engage with you and be honest with you, and they can be what you would call plain sailing really in as much as they're taking it seriously and they're not overly anxious. Of course, you'll also have patients, which I personally dislike, that come in and just say they want to look ten years younger. I believe that you will not achieve ten years younger, with some of these patients with dermal fillers and toxin—an awful lot more intervention would be required and they're the sort of people that will often walk away unhappy. The other ones that I dislike are the ones that are desperate to sign the paper without reading it or hearing about their procedure. They're a dangerous group. I tell them that it's my rules in my clinic and unless they listen to what I have to tell them and unless they honestly answer me when I ask them about their previous experiences then this isn't the clinic for them. The know-all patient is equally bad—they interrupt you all the time, they are convinced they know all about their treatment already constantly. Again, they're another group of people to whom I just say "my clinic, my rules" I get them to sit back and remind them we have to go through the process for their benefit.

And then of course we have the "query" body dysmorphic disorder patient. There is no way that I would try and make somebody happy who I suspected was body dysmorphic. There are some useful questionnaires that you can download from the internet which patients can fill in if you are suspicious that you have somebody like this. My advice would be always to refer them to somebody else, preferably with experience in that field.

Then we have the very nervous patient—I quite like the very nervous patient because they're the ones that do listen. They sometimes feel that they get more and more nervous as you proceed through the consultation, but I always reassure extremely nervous patients at the very outset that they will not be having a treatment today, and that often makes them feel an awful lot better. From here you can proceed through the consultation, establishing their expectations, without any fear on their part that you're going to present them with a needle and syringe at the end of it.

"If in doubt don't treat" has been my mantra for the last 20 years, and I stick by it and I still believe that it's the thing that's saved me from many potential disasters over the years. If the patient won't play ball with me I won't treat, so if somebody is not going to talk properly—sometimes you get really flippant answers on the patient information questionnaire and I won't accept that from a patient. I don't mind people who are comical and I don't mind people who are a bit jokey, but this is a serious part of the procedure and that's where I want them to stay, I want them to stay serious until we've established all the

parameters.

When it comes to dealing with expectations, if they're terrified they very often can't even imagine what they're going to walk out looking like. They don't know how they're going to feel, they anticipate every possible complication and there is no way that addressing that patient even with the tiniest treatment at that point. Nothing is going to make them feel any better, because they imagine that every possible adverse event is going to happen to them.

There are also people who come along with a list of practitioners that they've been to before. They have a serious problem I think when they've been to maybe five, six practitioners—very often people I know and respect, and they haven't been able to meet their expectations and they have a long list of complaints about them, and I think that that's another patient that is going to be seriously difficult to make happy.

Managing expectations is all about creating a picture for the patient that is honest, and they need to know the difference between something which is a normal treatment event—so, bruising, redness, pinprick marks, swelling—those are all normal as far as I'm concerned, anything that I could achieve by simply sticking a needle in them without putting any product in is nothing to do with, in my mind, an adverse event, so making sure that the expectations of something being wrong at the end of a treatment is not confused with something which is normal. The other expectation of how wonderful they will look with one cc of product—we all know that sort of patient that has a small budget but a big wish list; the patient that will walk in who wants to look like their friend, and their friend hasn't abused the sun for the last 30 years, their friend doesn't smoke and their friend doesn't abuse alcohol; all these factors are going to make it very, very difficult for you to end up with patients who are going to match their expectations by what you can achieve.

Another important part of dealing with patient expectations is to make sure that the aftercare that they receive will also not complicate the outcome of the procedure. The first thing patients do when you hand them a mirror post procedure is touch their face. I always say, no, hands off, don't touch your face again—your hands have just opened that door handle that somebody else has just opened before you. Reminding them to keep the area clean and make sure that they don't make anything happen that shouldn't happen. The use of cool packs is very useful for five or ten minutes after the procedure—you'll find that if you give them that little bit of time to soothe the area, to take the redness down, to apply some makeup if it is reasonable to do so.

There are lots of makeups that are available now which are safe to apply immediately post-procedure, though I'm always very reluctant to apply any makeup in the area where I've just introduced a cannula because I feel that the entry point is too large and it goes too deep. But I do think if you don't apply any makeup to a patient and you allow them to walk out of your clinic holding a cotton swab to their face to dab little pinpricks of blood, that the first thing they will do is find the nearest bathroom and reapply some makeup from the bottom of their bag. Arnica and vitamin K are very useful should you suspect that you have a bruise, and even if you just have somebody with a history of bruising it's very useful to make sure that they have a supply to apply.

In terms of exercise it depends on what you've done, how much you've used, and what sort of exercise the patient is interested in doing, but usually a good recommendation is 24 or 48 hours without any strenuous exercise. Things like saunas should also be avoided. And finally it's vital to ensure that they have an aftercare leaflet that will reiterate what you've told them and that they have a contact telephone number, and know that should anything untoward occur that it isn't a problem to phone you and that you should be their first port of call rather than their GP or their local A&E department.

Don't skimp on your aftercare advice, it's your last opportunity for avoiding patient-inflicted complications. Patients sometimes

are less bright then we think when it comes to looking after themselves and they can go straight from you to go and have their top lip waxed, or to go and have a facial, or to go and swim 50 lengths in the local swimming baths, and it will only cause complications that really and truly shouldn't have occurred in the first place.