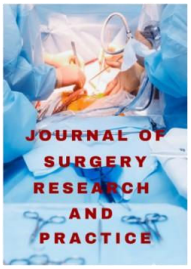

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Review Article

Neck, Face and Head Cosmetic Surgery Residency Training and its Practice in Oral and Maxillofacial Surgery: Updating and Evolving Perspectives

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Abstract

The evolution of clinical education in Oral and Maxillofacial Surgery (OMFS) and current diverse patients' demands for facial aesthetics, as a result of recent changes in technology, combined with today's engineering revolution for patient specific implants or virtual-surgical planning, along with new-sprung techniques for every day new set of insertable biomaterials and associated to higher dental/medical education environment requirements, set new horizons where a trending practice model in OMFS needs to be created and known as Neck, Face and Head Cosmetic Surgery or simply, Facial Cosmetics. These evolving perspectives should be incorporated into OMFS terminology, residency education programs and practice licensure to differ aesthetic procedures performed by Oral and Maxillofacial surgeons (OMFs) from those practiced in Orofacial Harmonization and Plastic Surgery specialties.

Keywords: Oral and Maxillofacial Surgery; Cosmetic Surgery; Cosmetic Surgical Procedures; Neck; Face and Head Comesis; Oral and Maxillofacial Surgery Education; Orofacial Harmonization; Plastic Surgery

Abbreviations

OMFS: Oral and Maxillofacial Surgery; FCD: (Brazilian) Federal Council of Dentistry; RCD: (Brazilian) Regional Council of Dentistry; MEC: (Brazilian) Ministry of Education and Culture; OFH: Orofacial harmonization; ENT: Otorrhinolaryngologist; OMFs: Oral and maxillofacial surgeon; NFH: Neck, face and head; OGS: Orthognathic Surgery; FCM: (Brazilian) Federal Council of Medicine; GA: General anesthesia; PACU: Post-Anesthesia Care Unit; NO: Nitrous oxide; ECG: Electrocardiogram; BVM: Bag-valve mask; LMA: Laryngeal mask airway; ETT: Endotracheal tube; AED: Automatic External Defibrillator; ACLS: Advanced Cardiac Life Support; CPR: Cardiopulmonary Resuscitation; BLS: Basic Life Support; ADA: American Dental Association; NR: Neonatal Resuscitation; ADA CERP: American Dental Association Recognition Standards and Procedures; USA: United States of America; CODA: Commission on Dental Accreditation; LEBO: Learning by bringing off; PFF: Paramedian Forehead Flap; PF: Pericranial Flap

Introduction

Oral and Maxillofacial Surgery (OMFS) Residency programs are not nonfluctuating and unrestrained strongholds of knowledge but every educational institution is located in an environment of continual transformation, most accelerated and influenced by artificial intelligence now.

There is a need for profound understanding the limits of dental, medical and surgical education. These three fields are distinct and their value should be recognized and commended for what they represent. OMFS Residency education in Dental Schools with its extension to hospital practice is now required to accommodate its curriculum for societal relevance and prepare professionals qualified and updated to the health market postulations.

Patients, laypeople, lawyers, faculty, dental/medical school/hospital staff, surgeons and social media trendsetters, informatics/social media environments create trends. These rapid changes in the characteristics of the Brazilian society demands a different patient healthcare protocol, and the perceived sense of body aesthetics do not match the current structure of clinical education in dentistry, more specifically in OMFS. Advances in surgical technology, the public use/misuse of medical (dis)information and social media's usefulness of Artificial Intelligence (AI) have transformed the demands not only for OMFS training but dentistry education for future clinical practice in Brazil.

The purpose of this article is to consider the transformation in the ever-evolving area of facial aesthetics and its clinical demands and how the Federal Council of Dentistry (FCD), Regional Council of Dentistry (RCD), Dental Schools and Hospital running OMFS Residency programs, and Ministry of Education and Culture (MCE) should act and react to it and thereby improve dentistry post-graduation and OMFS education.

Legal Aspects

Orofacial Harmonization (OFH) was recognized as a dental specialty by the FCD through Resolution FCD 198/2019, on January 29, 2019, regulating aesthetic and functional procedures on patients' face performed by general dentists [1]. The Brazilian Federal Council of Dentistry through Resolution No. 198 of 2019, only defines that specialization courses in OFH will be recognized if, as stipulated in Article 5: "They contain a minimum workload of 500 (five hundred) hours, divided into at least 400 (four hundred) hours in the area of concentration, 50 (fifty) hours in the related area and 50 (fifty) hours for mandatory subjects".

The annihilating problem does not specify the required hours for practical training. It could be one patient, ten or even none for one specific type of surgical procedure. It highlights, in Article 8 of the resolution, that the title of specialist in OFH must be obtained through training at an educational institution registered with the Council's system or regulated by the MEC though. This legalization did not come into effect without several concerns not only in dentistry but in medicine, as well.

The dispute over who has the legal right and qualification to perform facial aesthetics ended up involving general dentists, plastic surgeons, otorhinonolaryngologists (ENT), dermatologists and oral and maxillofacial surgeons, driven by sward wars, market competition and regulatory gaps.

Lots of ongoing debates over residency training, scope and extension of practice and the most important of all, patient safety are important and should continue in order to find the best term for such professional conflict.

Plastic surgeons traditionally are the benchmark for surgical aesthetics, focusing on comprehensive facial and whole body contouring. Some are board-certified or not in general and reconstructive surgery as well. They have done three years of general surgery and three years in plastic surgery. Yes, it is a long training but it is vital to mention here that their training is focused all over the body. If these six long years of training could be divided focusing only to neck, face and head, certainly it would decrease to one third or even less, in terms of full dedication and concentration neck above.

ENTs have three years training in their specialty after medical school, with a more limited surgical training when compared to plastic surgeons. Because of this, there are several postgraduate, continuing education and subspecialty courses available for this specialty, focusing on areas such as rhinology, otoneurology and specifically surgery for the ear, nose and throat.
Dematologists are focused on skin health and non-surgical aesthetics, including injectables and laser treatments, with specialized

training in facial dermatology. They have three years of residency in this field and its core competency is receiving training in basic dermatologic surgery which includes skin cancer excisions and common skin lesion removal. Many dermatologists pursue further fellowship training in surgical dermatology, and/or cosmetic procedures, covering less or more complex flaps/techniques for reconstructive surgeries.

General dentists who are specialized in OFH after five years in dental school, they have done between 12 and 24 months (1 to 2 years) of training in facial aesthetic procedures which are non-surgical even though invasive. This training can be in-person and blended learning modalities, with a workload that meets the resolutions of the FCD, such as Resolution 198/2019, focusing on practice and theory for certification but not specifying hands-on relevance.

Oral and Maxillofacial Surgeon (OMFs), after five years of dental school, they have done a residency with at least four years of intense surgical hospital training, from neck above, with extensive practice in facial trauma, dentoskeletal deformities and facial surgical pathology. Some residencies in OMFS offer a 6-year program. Any OMFs has a deep knowledge of Neck, Face and Head (NFH) anatomy. They have done extensive neck and face surgical dissections and are very comfortable in NFH resection and their reconstruction. Some of these specialists have done extra two to four years of regular study in OMFS to obtain a masters and a doctorate degree, respectively. Those professionals in this specialty of dentistry who regularly practice and are involved with facial aesthetic procedures, have done between two and three years of focused fellowship training, mainly surgical.

Therefore, it seems that those who have longer and more focused training in NFH, robust education in basic sciences such as anatomy, physiology, pharmacology, microbiology, histopathology, besides surgery and its principles are the ones who detain the best knowledge and surgical skills not only to perform NFH aesthetic operations but also are best qualified to correct possible complications of such surgeries, which can be associated to any invasive or not procedure. If that is the case, core conflicts such as scope of practice (inside and/or outside the mouth), regulatory differences (dental/medical councils issuing conflicting guidelines fueling intense friction with each specialty arguing for its unique qualification, boastfully questioning others' expertise), market ground "wars" (competition for this lucrative market) and dental or medical ethics (established to purposely lead to legal challenges and public confusion in relation to potential risks and complications from inadequate training), are completely irrelevant and are used are mere excuses to a certain group hegemony over NFH aesthetic procedures.

Stevão published an article showing the results of an Orthognathic Surgery (OGS) associated to rhinoplasty. He concluded that although we cannot forget what Gustave Aufricht said: "Rhinoplasty appears to be an easy operation but it is hard to produce consistently good results," corrective rhinoplasty associated with OGS surely always brings much more acceptable results than the high expectations the patient has when aesthetic nasal surgery is performed in isolation [2,3]. In recent years, this author incorporated plastic surgery techniques into OGS. Mutual understanding of what each discipline has to offer the patient in the process of achieving acceptable functional and aesthetic results is critical in treatment planning. The coordination and timing of the surgical procedure require excellent communication and cooperation among all professionals normally involved in OGS care, namely orthodontist, OMFs, anesthesiologists, among others. He also mentioned that the learning curve for this level of complex surgical procedure requires time and commitment from the OMFs but without a doubt, it is worth the effort.

The argument that general dentists should be able to integrate facial aesthetics as part of a holistic smile is ridiculous and makes no sense because they have no qualified training and zero surgical NFH skills. They should be entitle to take care of patients demanding minimally invasive treatment in the perioral area.

The FCD in its fast track desire to set a milestone for dentistry in Brazil caused instead a huge, possibly permanent, problem and endless dis-necessaries disputes between dentistry and medicine which will not be solved by that assemblage because it is not of their direct concern.

While all other specialties have several years of intense training in surgical procedures, the specialty of OFH finds a backdoor from needling procedures to access surgical ones, jumping to a better seat over the wings of this huge airplane called aesthetics. And this is what is happening all over the country in various OFH post-graduation courses, where ENT and dermatologists are teaching more advanced procedures (neck and head) to general dentists who have average one year and half of only facial aesthetics. Those medical doctors are not realizing they are in full violation of their own medical code of ethics by teaching

exclusive medical acts, such as, diagnosis, prescription and medical treatment, which cannot be taught to nurses, technicians or other non-medical professionals, even under supervision, according to Federal Council of Medicine (FCM) Resolution No. 1.718/2004 [4].

If the excuse is that general dentists should perform full surgical aesthetic procedures on a patient's face because they become competent practicing, then it is agreeable that dental lab technicians are far more competent than general dentists to clinically perform any dental prosthodontics and orthodontics because they technically know infinitely more and have better hand motor skills; they just need the certificate to validate their abilities.

Cosmetic surgeries involve elective procedures performed exclusively under intravenous sedation provided by an OMFs or General Anesthesia (GA), provided by a medical anesthesiologist. A general dentist performing facial aesthetic moderate invasive procedures may operate on patients under GA but it must be performed by an anesthesiologist. Since its publication in the Official Gazette of the Union, on 11th of November of 2025, the theme deep sedation and GA in dental offices have a new normative, which establishes mandatory Post-Anesthesia Care Unit (PACU) inside the office with all necessary equipment and gases for adequate patient recovery [5]. Also, a dedicated anesthesia professional, aiming patient safety. That decision impacts more complex procedures with controlled drugs, not just local anesthesia and/or conscious sedation (relative analgesia) with Nitrous Oxide (NO) gas. Therefore, the same dentist cannot perform dental procedure and administer deep sedation simultaneously; a separate professional is required. FCD has committed to updating regulations and the sector is seeking compliance.

For minimal IV sedation, any dental office should have readily available these items: 1) Basic IV supplies such as: a) cannula (e.g. 22G), b) syringes (3 mL, 5 mL), c) saline solution 0.9%, d) tape, e) antiseptic wipes, f) needles (several sizes) and g) elastic tourniquet. 2) Gases and suction such as: a) oxygen to be delivered through nasal prongs or mask, b) NO to be delivered by mask, c) potent suction system, d) Yankauer aspirator, e) oral airways, Magill forceps (for basic airway adjuncts). 3) Essential monitoring equipment such as: a) pulse oximeter, b) blood pressure cuff, c) 5-lead Eletrocardiogram (ECG) and d) capnography. 4) Emergency airway/resuscitation gear or devices such as: a) Bag-Valve Mask (BVM), b) Laryngeal Mask Airway (LMA), c) a great variety of Endotracheal Tube (ETT) for emergency intubation, d) portable AED (Automatic External Defibrillator), e) glucometer. 5) Emergency/resuscitation drugs such as: a) epinephrine/adrenaline (for severe allergy reaction or asthma), b) chewable aspirin (chest pain and/or mypcardial infarction), c) nitroglycerin (chest pain), d) albuterol (asthma and bronchospasm), e) diphenhydramine (mild allergy reaction), f) glucose (hypoglycemia), g) glucagon injection (severe hypoglycemia), h) diazepam (seizure), i) corticosteroid injection (severe allergic reaction), j) labetalol or esmolol (severe hypertension), k) reversal agents like flumazenil and naloxone (nasal spray). If these requirements are not implemented and enforced by FCD and RCD, patients have their life at risk. There is no excuses for delaying this normatization.

ACLS (Advanced Cardiac Life Support) certification has to be mandatory for any surgical procedure performed in the office by dental or medical doctors, with or without sedation; emergency preparedness is crucial, not optional [6]. A trained team familiar with Cardiopulmonary Resuscitation (CPR), emergency drug administration and airway management learned from Basic Life Support (BLS) training is essential [7,8]. All these certifications in ACLS, CPR and BLS have to be renewable every two years, enforced by the RCD in other to obtain the licensure for clinical practicing.

Accreditation for dental professionals is no exception and dental practitioners must meet current the American Dental Association (ADA) standards with these continuing education credits: a) ACLS with 8 ADA credits for certification and 4 ADA credits for recertification every two years [9]. b) BLS certification with 4 ADA credits for certification and 2 ADA credits for recertification. c) PALS (Pediatric Advanced Life Support) with 8 ADA credits for certification and 4 ADA credits for recertification. d) NR (Neonatal Resuscitation) with 8 ADA credits for certification and 4 ADA credits for recertification. The continuing education and periodic reevaluation for dental providers are in compliance with the ADA CERP (Recognition Standards and Procedures) [10].

General dentists in Brazil are not even trained in intramuscular injections let alone performing phlebotomy. Dental professionals performing aesthetic procedures are more concerned with belonging to an international aesthetics academy and have it publicized on social media than possessing the minimum training required for peers in other countries like the United States of

America (USA), United Kingdom, Australia, Singapore, Canada and Ireland. Some countries, like Australia, requires CPR recertification every 12 months.

Dental Schools in Brazil yet have a long way to go and up to the moment of this publication, ACLS, CPR and BLS certifications are not a requirement in Brazil for dental nor medical professionals to obtain their professional license, which is a shame! Hence, unfortunately, these regulations are being violated several hundreds of times, in hundreds of dental offices all over Brazil due to inadequate physical structure as ruled.

Educational aspects in Neck, Face and Head (NFH) Cosmetics

The recognition by the FCD does guarantee dentists to use their license to perform not-invasive or invasive procedures on patients searching for facial aesthetic improvements but it does not automatically warrant them (dental professionals) a broad-shouldered training in this field.

FCD transfers that responsibility to Dental Schools or even worse, to non-accredited private small post-graduation entities interested in making big money out of dentists, promising heavens, who are willing to immediately transfer that costs to their patients and enter the so called select class of professionals with the illusion of have acquired a golden egg-laying hen.

Those educational institutions are required to obtain certification from MEC and follow a standardized curriculum proposed by RCD. But there is no supervision from any side.

A minimum hours of training are somewhat followed but under RCD auspices a requirement of minimum number of procedures performed with a case log system should be enforced to guarantee trainees fine motor skills. A simple case log system to be imposed could be a web application within RCD where the trainee would be required to log his/her clinical experiences, with patient data, etc.

Regrettably, Brazil does not have any accreditation standards nor a dedicated body inside MEC to set such regulations, as the Commission on Dental Accreditation (CODA), a counter-part in the United States Department of Education. Because of this, yearly dozens of small post-graduation entities materialize themselves into the education realm with poor or completely lacking patterns for professional adequate and standardized training in dentistry.

A normalcy is a group of professionals with some sort of clinical experience and sometimes no background in didactic and higher education teachings, get together to set up a post-graduation class, offering their expertise to those entities, sharing the dividends from student fundraising. The educational institution offers a certificate which is valid, sometimes with MEC approval or not, more or less competent to adequately train their post-graduated students.

Ethical and bioethical concerns within a healthcare system basically convergent in offering only bodily aesthetic procedures, emphasizing that patient care should prioritize well-being over financial gain or financial interests is a must in dental/medical education. It is about beneficence where health care providers place utmost importance on the welfare and well-being of their patients [11]. Seeing a patient first as a human being speaks to a desire for healthcare equity, where access to any type of medical services, prioritizing clinical needs of patients is not limited their ability to pay. In the ever-changing health care landscape, upholding ethical principles as the guiding force in the decision-making process is paramount. The development of aesthetic (surgical or not) care models must be guided by ethical principles such as justice, beneficence and autonomy, ensuring alignment with society's ethical values and high-quality care [12].

Accordingly to Assael, surgical training in OMFS residency is essential because the specialty involves complex procedures for mouth, jaw, face, neck and head conditions, requiring deep knowledge of both dentistry and general surgery principles, managing medically complex patients and performing reconstructive and aesthetic surgeries, necessitating rigorous, hands-on experience, often including core surgical training and specific surgical skills courses for competency [13]. This training ensures surgeons can handle everything from simple oral surgeries to intricate facial trauma, tumors and complex reconstructions, often requiring dual dental and medical degrees for comprehensive care. It is not about performing aesthetic procedures but obtaining surgical training to better perform invasive cosmetic surgeries. Comprehensive scope in OMFS (from third molar removal to

neck, face and head cosmetics), core surgical skills (practicing local and learning to provide endovenous moderate and deep sedation and general anesthesia, managing postoperative care), hands-on experience (start assisting senior surgeons/professors and then performing procedures under one-to-one supervision throughout resident's training), management of complexity (manage sick patients and deal with complex NFH anatomy), advanced skills (perform microscopic surgery to micro-vascular surgery), technology competency (use digital tools for virtual surgical planning), research (clinical mindset based on scientific evidence, methodology and epistemological case presentations) are not exaggerate requirements but key aspects of training an individual to perform NFH surgeries [14,15].

The biggest difference for a resident during his education and learning years, is a teacher who truly wants to enlighten someone. A tutor who believes in his/her resident and supports them, throughout the process. A mentor who allows them to perform procedures, while standing next to them, guiding, giving advices and intervening when needed. It is a teaching technique/process developed by the author called "LEBO" (Learning by Bringing Off) which means gaining knowledge, understanding and hand skills through active participation and real-clinical application, rather than just passive study of theory and/or observing. Without this mutual trust and pupil singular encouragement, it is very hard for any resident to grow surgically. "Lebo" in Hebrew means "approach".

OMFS is a clear intersection between dentistry and medicine, which surgical full spectrum training of modern OMFS offers the necessary qualification for OMFs to manage his/her patient in integral aspect, not just the aesthetic concerns, accordingly to Stevao and Bath [14]. A full training also ensures that OMF surgeons have all the skills to manage surgical complexities, potential risks, preventing adverse events during cosmetic surgeries.

New Terminology in Oral and Maxillofacial Cosmetic Surgery and its new framework

The term "plastic surgery" derives from the Greek word plastikos. Its meaning is "to mold" or "to shape" and the term pertains to the surgical art of shaping body tissue. Plastic Surgery is a broad surgical specialty focused on restoring, reconstructing and improving appearance and function, covering from severe body burns, birth defects to aesthetic enhancements, using the body's own tissues to mold and form new structures.

A new proposal for dentistry is to create another specialty to be called Neck, Face and Head Cosmetics or in short, Facial Cosmetics, setting it apart from Orofacial Harmonization and Plastic Surgery. The name Cosmesis or Cosmetic Surgery is not new but should permanently substitute the term Plastic Surgery. Cosmesis refers to the preservation, restoration (reconstruction through hard and soft tissue grafts), and/or enhancement/reshaping of physical appearance, especially after medical treatments or injuries, focusing on making things look natural and beautiful, like realistic prosthetic covers and/or minimizing surgical scars, rather than just concentrate in function. It is about achieving a pleasing aesthetic result, often involving careful surgical techniques, like very meticulous sutures or creating lifelike prosthetic facial and head covers for those patients victims of severe accidents or local cancer. This term Cosmesis shall be used to NFH surgery when any procedure, invasive or not, is performed by an OMFs.

This new specialty and certificate/license should be issued by the RCD and limited to Oral and Maxillofacial surgeons during their residency training in a Dental School and Hospital recognized by MEC or also as an extended fellowship training for those who have not received such training during the OMFS residency on their educational institution program. Specialty taught by OMFs professors who have extensive experience and expertise in NFH cosmetic procedures and have dedicate part of their lives to such field.

Licensed or certified OMFs or board certified in Cosmesis should be known, recognized and referred to as Oral and Maxillofacial Cosmetic surgeons then. It is counter-productive to continue any challenge with medicine and its specialty of Plastic Surgery.

It follows below a few examples of a new terminology and designations for neck, face and head cosmetic surgeries which should be included in the dental/medical dictionary from now on:

1. Blepharoplasty = Blepharocosmesis. Removes excess skin and fat from upper and/or lower eyelids
2. Rhinoplasty = Rhinocosmesis. Reshapes the nose for cosmetic improvement
3. Rhinoseptoplasty (or Septorhinoplasty) = Rhinoseptocosmesis or Septorhinocosmesis. It is a combined surgical procedure

that corrects both the aesthetic appearance (rhinocosmesis) and the functional breathing problems (septocosmesis) of the nose in a single operation. To correct the nose position it vital to correct the nasal septum position and when a deviated nasal septum is present, one procedure cannot be corrected without the other being addressed as well. Correcting the nasal septum position will impact the airflow for better breathing, reducing snoring and achieving facial harmony. Form and function are addressed in one single procedure

4. Otoplasty = Otocosmesis. It is a cosmetic surgery to reshape the ears, addressing problems like prominent, protruding, uneven or misshapen ears by altering their size, position or shape. It creates a more balanced and aesthetically pleasing appearance, often involving "ear pinning" to bring them closer to the head
5. Genioplasty = Geniocosmesis. Implants or reshaping to enhance chin projection
6. Mentoplasty = Mentocosmesis. A cosmetic surgery to reshape the bony chin, either by augmenting it with implants, to create better facial harmony and proportion
7. Jaw Contouring = Mandible Cosmetic Reshaping. It is a cosmetic procedure, normally surgical, used to reshape and define the mandible line for a more sculpted, symmetrical and aesthetically pleasing look
8. Eyebrow Lift or Forehead Lift = Eyebrow Cosmetic Lift.Raises sagging eyebrows and smooths forehead wrinkles
9. Neck Liposuction = Neck Cosmetic Liposculpture. Removes cumulative fat, often from the chin/neck area and jowls
10. Neck Lift or Plastysmaplasty = Neck Cosmetic Lift or Platysmacosmesis. Addresses sagging neck skin and prominent bands
11. Facelift (Rhytidectomy) = Facecosmesis or Face Comestic Lift. Tightens underlying muscles and removes excess skin from the lower face and neck
12. Z-plasty = Z-cosmesis. It is a versatile reconstructive surgical technique that uses two triangular flaps to revise scars, improve function and make them less noticeable by changing their direction and breaking up tension
13. Arthroplasty = Arthrocosmesis. Also called of Total Joint Replacement Surgery (TJRS). This term is a misnomer, innaccurate but wrongly employed. Two new and more precise words (neologism) should be used here, arthroectomy (arthro = joint; ectomy = surgical removal) or arthrocosmectomy (arthro = joint; cosmesis = repair of function and form; ectomy = surgical removal), meaning the surgical removal and reshaping of parts of a specific joint. It an orthopedic procedure to replace a damaged or diseased joint (in OMFS, the Temporomandibular Joint - TMJ) with an prosthesis to relieve pain and restore function due to severe osteoarthritis. The surgery involves removing worn-out bone, disc and ligaments, implanting components made of metal, poliethylene and/or ceramic. It improves mobility and Quality of Life (QoL) when conservative treatments fail
14. Primary Flaps for Secondary Cosmesis: Even though these primary surgical procedures are not purely for aesthetics but they laid down the foundation/pillars for a subsequent cosmetic surgical procedure. Some OMFs like the author dedicate themselves for this type of surgical procedures for skin/cartilage/periosteum cancer patients. a) Paramedian Forehead Flap (PFF), is a gold-standard technique for repairing large or deep nasal defects, using forehead skin on a blood vessel pedicle to restore contour, texture and projection, often in staged procedures with cartilage grafts for complex tip/ala defects, leaving a usually inconspicuous scar on the forehead. It's favored for its excellent tissue match. b) Pericranial Flap (PF) used to cover the calvarium/skull bone. Common technique used to cover exposed bone after skin cancer removal. The specific reconstructive approach depends on the size and depth of the defect. When skin cancer on the scalp is deeply invasive, surgery often requires removing not only the skin but also the underlying skull bone (calvarium) or its covering layer (periosteum) to ensure all cancer cells are removed

Obviously the terms should not be limited to those above but where “plasty” is to be found in any NFH plastic surgery it should be substituted for “cosmesis” or “cosmetic” which one fits better.

Oral and Maxillofacial Cosmetic procedures can be divided into 1) Non-surgical and 2) Surgical.

1) Non-surgical procedures are divided into 1.1) Non-invasive and 1.2) Minimally invasive procedures. All of them can be performed by Orofacial harmonization specialists.

1.1) Non-invasive procedure are: a) Hydrafacial: multi-step treatment for deep cleansing, exfoliation, extraction and hydration. b) Chemical peels: exfoliate skin with acids (glycolic, Trichloroacetic acid - TCa) to reveal brighter, smoother skin, reducing acne and fine lines. c) Laser treatments: resurfacing (CO_2, fractional) for texture, sunspots and wrinkles, Intense Pulsed Light (IPL) targets pigmentation.

1.2) Minimally invasive procedures such as: a) Neurotoxins (Botox): relaxes muscles to smooth dynamic wrinkles (forehead, frown lines, crow's feet). b) Dermal fillers and/or Bio-fillers: injectable gels (hyaluronic acid) and liquid-Platelet Rich Fibrin (l-PRF) liquid temperature treated, adding volume to plump lips, cheeks and smooth static lines. c) Allogeneic fat injections: products derived from sterilized human donor fat tissue. These products are broadly categorized as Allograft Adipose Matrix (AAM) or tissue-based fillers and are known by brand names such as alloClae™, Leneva® and Renuva®. Unlike traditional autologous fat transfer, which uses a patient's own fat harvested via liposuction, allogeneic injections use donor tissue, eliminating the need for a surgical fat harvesting procedure on the recipient [15-18]. d) Microneedling/PRP: tiny needles create micro-injuries to stimulate collagen, often combined with Platelet-Rich Plasma. e) HIFU (High-Intensity Focused Ultrasound): ultrasound energy tightens skin and stimulates collagen deep within. f) Fat dissolving injections (e.g. Kybella) breaks down fat under the chin (double chin).

2) Surgical procedures list has already been aforementioned.

Conclusion

The above division is a clear cut which will differentiate dentistry and medicine; a specialist in Orofacial Harmonization from a specialist in full Neck, Face and Head Cosmetic Surgery, reserved exclusively for Oral and Maxillofacial Surgery. Again, Plastic surgeons will continue performing Plastic Surgery. A good health care experienced team is more important than making a good sum of money out of limited (by training) facial cosmetic procedures. This new vision for Facial Cosmesis and evolving perspectives must be initiated and promulgated in all post-graduation courses of OFH and OMFS residency programs. It will help to eradicate the constant friction between dental and medical fields. Case conferences should be used to explore care options and assess aesthetic outcomes based on the features of the post-graduation. For those patients who have to be hospitalized for more extensive procedures, length of stay, operating room time, complications, are quality measures to examine progress of the trainees as a multifactorial evaluation. The same level of surgical and post-operative care should be provided for patients in a day-hospital format.

Accordingly to Arnetz, Goethe and Reyelts, assessing the satisfaction with the care model of both patients and the care team (residents, faculty and staff), using verifiable survey tools, can be used to improve program-specific. There are several myths which should be discarded when NFH cosmetic procedures are concerned, such as, but not limited to: 1) Medical doctors have better surgical skills than dental surgeons. 2) Medical surgeons know more than OMFs. 3) All medical/OMFs residents are or should be competent in all aspects of their specialty when they complete their training. 4) The more theoretic knowledge the better hand motor skills for surgical procedures. 5) The better hand dexterity the better the aesthetic judgment, fundamental criterion for a surgeon who wants to practice cosmetic procedures on a daily basis. Certainly, an intelligent, curious and proficient dental/medical professional/surgeon with time will become a better and more experienced one but only if he/she is fully committed to their specialty.

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Ethical Statement

The project did not meet the definition of human subject research under the purview of the IRB according to federal regulations and therefore, was exempt.

Informed Consent Statement

Informed consent was taken for this study.

Authors' Contributions

The author ELS specifically provided the new concept of Facial Cosmetic Surgery specialty for Oral and Maxillofacial Surgery outlined in the article, based on his personal experience practicing in Brazil and the USA. Both authors contributed collecting scientific information and revising this paper.

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