

Dentistry Clinical

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Facial aesthetics – starting out

Dr Bob Khanna is a facial aesthetics expert who has pioneered the way for all dentists to enter this arena by providing comprehensive training in botulinum toxin and facial dermal fillers. We spoke to him about the world of facial aesthetics and why all dentists are so keen to get involved . . .

You were the first dentist in the UK to get involved in facial aesthetics. How did you first become interested in this area?

In 1996, whilst on an implant training programme in Canada organised by Dr Carl Misch, I was introduced to a few dermatologists who recommended I visit the eminent Doctors Jean and Alastair Carruthers who had discovered the cosmetic use of Botox in the early 80s. After watching them perform a few procedures on patients I was incredibly inspired. On my return to the UK I began to research the full spectrum of non-surgical facial rejuvenation procedures that were possible, attending masterclasses by Professor Tim Flynn (North Carolina, USA) and Dr Phillip Levy (Geneva, Switzerland).

Since then, I have been heavily involved with the facial aesthetics industry and have helped modify and develop techniques to enable the treatment to be performed in a virtually pain free manner. Due to the fact that there were no formal hands on training programmes available and the fact that I was constantly being asked by colleagues for training, I felt it was important to form the Dr Bob Khanna Training Institute in order to help create a standard for the practice of botulinum toxin and dermal filler treatments in the UK.

Do you feel that dentists should carry out Botox procedures and treatments involving dermal fillers?

Yes, absolutely. In fact, when I ventured into facial aesthetics there was an awful lot of scepticism and antagonism from other medical professionals to a dentist being involved in this area. Hence it became a challenge for me to enlighten them as to our extensive undergraduate training in head and neck anatomy, physiology, biochemistry and pharmacology, coupled with the manual dexterity required to carry out procedures. Another reason why I feel very passionate about dentists carrying out such procedures is due to their understanding of optimum clinical environments, good communication skills, medico-legal considerations and of course the ability to perform intra and extra oral local anaesthetic. This can be particularly beneficial for patients whilst using dermal fillers for lip augmentation and for the treatment of perioral and naso-labial lines in order to perform a totally pain free procedure (see Figures 1a and b). Hence, with respect, I not only feel that dentists are entirely capable of carrying out these procedures but they are probably the most competent medical professionals to perform non-surgical facial aesthetic treatments.

What is the general feedback from patients about dentists performing such procedures?

Excellent! Patients seem to inherently understand that dentists are used to giving painless injections in an area, which totally invades their 'social bubble'. They are also aware of the fact that dentists are used to performing very intricate procedures in their mouths which often involves a great deal of skill and care. Coupled with the fact that most regular patients, by definition, trust their dentist implicitly, they are extremely enthusiastic towards them performing intricate injections facially.

It is understood that you are actively involved in discussion processes with regard to the Cosmetic Surgery Inter-speciality Committee (CSIC) and the Healthcare Commission. What is the stance of the Department of Health and the Healthcare Commission with regard to dentists being able to carry out such procedures?

I have been in active dialogue with these bodies for over two years now, with the sole emphasis to ensure that dentists are duly represented and not disallowed from carrying out non-surgical facial rejuvenation treatments. Following such high level meetings, I am pleased that the response from these groups has been extremely positive towards dentists. As with all medical professionals involved with such treatments their main concern is that the aesthetic practi-

Dr Bob Khanna is a cosmetic and reconstructive dental surgeon. He runs clinics in Ascot, Harley Street and Manchester, and carries out a full spectrum of treatments from aesthetic dentistry, surgical implantology and bone regeneration procedures to full-mouth rehabilitation. He was the first dentist in the UK to venture into facial aesthetic procedures utilising Botox and dermal fillers over 10 years ago. Internationally renowned as a leading lecturer, trainer and expert in aesthetic medicine, Dr Khanna has trained over 4,500 doctors, dentists and plastic surgeons in non-surgical facial rejuvenation procedures and has pioneered many of the techniques.



Figure 1a: Patient aged 64 years old, before treatment

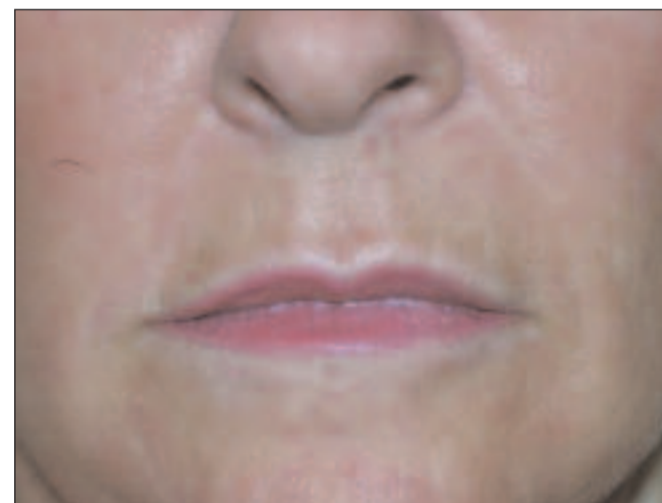


Figure 1b: Patient three months after dermal filler treatment to nasolabial lines, perioral lines and upper lip

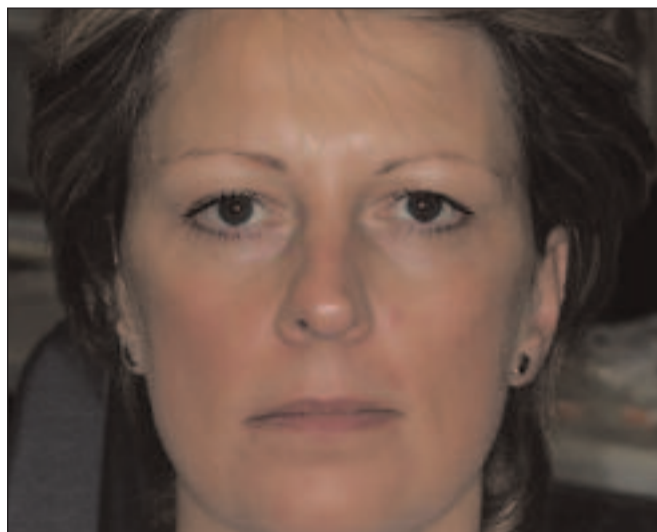


Figure 2a: Patient aged 40 years old, before treatment (note heaviness of upper eyelid complex i.e. hooding).



Figure 2b: Patient after Botox browlift treatment. Note: the less tired appearance of the eyes and improved brow shapes.

tioner is appropriately trained and is carrying out such procedures in optimum clinical environments so as to protect patients interests.

What is the basic training required to start carrying out such procedures?

Since I started teaching over eight years ago there has been an increase in the number of courses available. At our institute we have full day courses consisting of theory, practical demonstrations and the all-important hands on sessions.

The beginner Botulinum Toxin (Botox/Dysport) courses are designed to help dentists get under way with injecting, it's a great starter course because at the end of the day they will leave with the skills and knowledge to treat patients for the most commonly asked areas. I have taken the approach of beginner followed by advanced courses for Botulinum Toxin because I firmly believe that if practitioners want to be able to treat patients with predictable and reproducible results and minimise complications, it is vital that this learning experience is not rushed. I don't believe you can start injecting the most intricate areas of the face having just spent one day training. Indeed the Health Care Commission are particularly concerned about a 'crash course' approach to facial aesthetics. There is also our dermal filler course where delegates will learn how to treat a patient on the course for lips and nasio-labial lines.

After the three courses delegates will have formally completed the training program enabling them to treat most cases. Masterclasses are available for those experienced practitioners wishing to extend their knowledge of facial aesthetics even further. This is an ideal way of keeping abreast of the latest developments, materials and techniques required to treat even the most challenging of cases.

Once appropriately trained, how easy is it for a dentist to get started and what tips can you give to dentists in this position?

It is incredibly straightforward for any dentist to get started once

they have been appropriately trained. The reason for this is they are already based in an ideal clinical environment with a regular throughput of patients. With carefully delivered information, existing patients can be educated in the pros and cons of non-surgical facial rejuvenation. For this reason, I cannot stress enough the importance of communication skills. Communication is the single most important key to the success of an aesthetic practice. It is imperative that all key members of staff are trained appropriately on facial aesthetic procedures. It is amazing how a simple conversation with a knowledgeable receptionist or nurse can result in patient acceptance of treatment.

I would also suggest marketing existing patients with these new range of treatments via newsletters and the practice website as well as hosting a 'cheese and wine' or better still 'champagne and canapes' evening to launch such treatments. Marketing key patients is always a good starting point as they will naturally act as your evangelists, often without the need for prompting!

Although it is commonly known that a lot of people nowadays want to have some form of facial rejuvenation, what would you say is the patient demand for treatments?

The demand is definitely on the increase especially due to the influence of the media on today's society. Females have for years exploited the benefits of grooming and have understood the importance and benefit of looking their best. For the last few years males have also realised the merits of maintaining themselves. Only very subtle changes are required and it is true that currently the demand for non-surgical rejuvenation is often greater than for cosmetic surgical treatments. In fact, what I am finding is that patients will often try the non-surgical route first, before considering a surgical alternative, especially pertaining to treatment involving Botox and dermal fillers. I personally believe that this is a sensible course of action for any patient before embarking on more invasive treatment. Indeed, it is

often entirely possible for a patient to achieve quite acceptable results non – surgically. (See Figures 2a and b illustrating an alternative to a surgical brow lift-a 'chemo-brow lift' with botulinum toxin).

All treatments carry a certain element of risk, what can go wrong and how can it be rectified?

The key to minimising complications is a combination of appropriate training to enable optimum appreciation of risk assessment and a cognitive approach to the limitations of treatment. Pertaining to Botox treatment the most common complications are brow ptosis and eyelid ptosis. These are primarily due to incorrect delivery of the toxin into neighbouring anatomical sites via poor injection techniques and incorrect anatomical considerations and patient assessment. Fortunately these complications are only transient, not permanent and would not typically last more than two to three months. However, remedial measures can be undertaken to expedite the resolution of such complications.

Pertaining to dermal fillers, I would always recommend the use of non-permanent materials particularly the hylauronic acid type fillers since the incidents of foreign body reactions is relatively very low. However, common complications occur if the materials are injected too superficially in the dermis resulting in 'sausage' like lesions which can be carefully manipulated and thereby minimised. Naturally poor injection techniques can result in transient damage to anatomical structures such as blood vessels, neural and muscle tissue. Hence the importance of the appropriate hands on training cannot be stressed enough.

Is it possible to mix dental treatment with facial aesthetic treatment on the same patient?

Yes absolutely. There is no reason why a patient having anything from a simple restoration to a full mouth rehabilitation can't undergo treatment with Botox or dermal fillers at the same appointment. In fact, due to the fact that the patient may already be locally anaes-

thetised this can be an advantage for the patient. What I have found in clinical practice is that patients requesting any form of cosmetic dentistry will more often than not request some form of facial rejuvenation procedure. This is obviously because the synergy of a smile makeover and facial rejuvenation leads to improved facial aesthetic results. A typical example of this is illustrated in Figures 3a to 3f.

Is this a profitable source of income for the typical dental practice?

Yes indeed. I will be discussing this in more detail in later articles. But just to wet ones appetite, if a dentist was to treat two patients a day for just Botox treatment with an average conservative retail cost of £300 a session per patient. This would amount to a total treatment time of approximately 30 minutes a day, after excluding material expenses this would project a net income of approximately £100,000 per annum! This figure could be substantially increased if dermal fillers are utilised and the number of patients undertaking such treatments increases. Let's not forget that this source of revenue is in addition to any dental treatment carried out in the practice. The additional overheads required to carry out such treatments is entirely negligible.

Your patients probably ask you this all the time, but have you had any such treatments?

Yes, I don't look bad for 65 do I? Joking aside, I have had a small amount of Botox on my forehead on two occasions in order to prevent the lines that I do have from getting worse. I do believe that you can't properly recommend such rejuvenating treatments to your patients if you have not experienced the treatments yourself. Patients will respect you more when you practice what you preach and look good for your age.

• For all course enquiries at the Dr Bob Khanna Training Institute please contact Sonia Pal at sonia@drbobkhanna.com or 07956 378526. For all IAAFA membership enquiries please visit www.iaafa.net



Figure 3a and b: Patient aged 40 years old before smile makeover (upper arch only)



Figure 3c: Removal of old crowns and refined preps



Figure 3d: New lava crowns fitted improving the aesthetics



Figure 3e: Patient smiling after aesthetic rehabilitation



Figure 3f: Occlusion reorganised and stabilised



Figure 3g: After mild Botox treatment to upper forehead, frown and crows feet

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