



Dr Charles Ferber

qualified in 1976 at the Royal London Hospital Dental College and has been in private practice in Wimpole Street for more than 25 years. He has maintained a special interest in aesthetic and restorative dentistry and in 1999 was the co-author of a published article on reconstruction of severe cases with implant restorations in *The International Journal of Periodontics and Restorative Dentistry*. He is a founder member of the Society of Dental Studies and a member of the Alpha Omega Study Club, the Association of Dental Implantology and the International Academy of Advanced Facial Aesthetics (IAAFA).

CONSULTATION

PERIOD

DR CHARLES FERBER ON PRE-OPERATIVE EVALUATION OF THE AESTHETIC PATIENT

The 21st century has been marked by a heightened cultural awareness and acceptance of cosmetic procedures for both men and women and males. Television programmes such as *Extreme Makeover* and *10 Years Younger* reflect an unprecedented celebration of aesthetic procedures, both surgical and non-surgical.

It is not surprising that the current level of demand for cosmetic procedures is greater than ever before. As the demand for aesthetic procedures continues to grow, a reliable means of assessing the patient is required.

THE PRACTITIONER'S ROLE IN PATIENT SELECTION

The aesthetic practitioner plays the roles of physician, therapist, surgeon, psychiatrist and artist. First and foremost, the aesthetic practitioner must understand the motivation of the patient. This is not always easy, as the patient may mask their true desires.

A poor outcome is likely due to either poor patient selection or technical error. All individuals suffer some alteration or distortion in self perception. These distortions tend to magnify perceived imperfections and minimise positive attributes of the skin and body. The practitioner should explain what can and cannot be accomplished with all treatment options.

The definition of an acceptable outcome should be jointly established by the practitioner and the patient prior to any aesthetic procedure. Failure to do so may result in misunderstanding and a dissatisfied patient.

PSYCHOLOGICAL CONDITIONS

There are certain conditions that must be recognised at the initial consultation and this knowledge can be used to make informed patient recommendation in regards to proceeding with an aesthetic procedure and/or psychiatric evaluation.

THE NEUROTIC PATIENT

The neurotic patient is characterised by excessive worry, anxiety and somatic (body) complaints.

These patients usually ask numerous, sometimes repetitive questions which often require detailed and technical explanations. They may also be obsessed about possible post-operative complications, which they usually are aware of in detail. They are very needy of a lot of reassurance.

Properly managed, neurotic patients often make excellent candidates for aesthetic procedures. It is important to identify problems pre-operatively and properly address all issues. More time should be allocated to these patients.

THE PSYCHOTIC PATIENT

The most commonly seen psychotic disorder is schizophrenia. These patients have disorganised thoughts, flight of ideas and are incapable of introspection. They can appear to be emotionless and humourless. The paranoid schizophrenic also incorporates thoughts of persecution and selfish behaviour. Violent behaviour has also been reported. A psychiatric evaluation should be pursued.

PATIENT CONSULTATION

PERSONALITY DISORDERS

Personality disorders manifest as behaviour problems and these patients are often able to disguise their personalities, making diagnosis difficult.

THE NARCISSISTIC PATIENT

The narcissistic patient is usually smart and elegant in appearance and often obsessed with subtle, even imperceptible physical flaws. Their opinion of themselves is often grandiose and they are sometimes name droppers. However, ironically, they may have fragile egos or even low self-esteem. These patients are prone to post-operative unhappiness and dissatisfaction. Be on guard and treat appropriately.

THE MANIPULATIVE PATIENT

Manipulative patients tend to idealise their current practitioner while denigrating former physicians. They categorise people into 'us' versus 'them'. They can lull you into a false sense of security but can turn against you or your treatment quite quickly. Proper pre-op assessment with good photos and charts as well as letters to the patient with full explanations is very important to avoid possible problems later on.

THE MALINGERER

The malingeringer fakes symptoms and illnesses. The motive is usually monetary. This condition may cause the physician to feel uneasy. Usual findings during examination include complaints that are grossly out of character with physical findings. Tread carefully – it is best to obtain second opinions from one or even several colleagues so that all future eventualities are covered.

THE DEPRESSED/MANIC PATIENT

The depressed patient complains of minimal joy in things that he/she formerly found pleasing. They either have difficulty in sleeping despite being tired, or sleep excessively with little sensation of rest. They complain of poor energy and motivation.

The underlying causes may be complex and an adequate social and family history may help to understand these patients.

Studies have shown that many of these patients can feel much better following aesthetic procedures and hence can be good candidates for this type of treatment.

The manic patient usually has flight of ideas, pressured speech and is dishevelled in appearance. They rarely present for aesthetic procedures.

However both groups of patients, once treated for their underlying disorders are excellent candidates for aesthetic procedures and may even show further improvement of symptoms after treatment.

PATIENTS WHO ARE 'ADDICTED' TO PROCEDURES

We see from the press certain well-known individuals who have had multiple cosmetic procedures. We can have our own opinions about this subject in theory, but if one of these patients comes in for consultation, great care and discretion has to be used.



BODY DYSMORPHIC DISORDER (BDD)

In summary, this group of patients have an inordinate concern for slight or imagined aesthetic defects. These patients' lives are significantly disrupted by their obsession with their perceived physical flaws. The most common focus of the patient's dissatisfaction is the skin, face and nose. Other disorders that may accompany BDD include obsessive-compulsive disorder, social phobia, eating disorders (anorexia/bulimia) and depression.

It is well documented that patients with BDD are not good candidates for aesthetic procedures as they are seldom, if ever, satisfied with the result. These patients are best referred to an appropriate medical specialist to get help.

Please refer to the February 2007 issue of *Aesthetic Medicine* for an article on BDD by Dr Steve Harris.

IN SUMMARY

The practitioner should pay special attention to their gut feeling about the patients they see. A sense of unease should trigger a more in-depth evaluation. Preventing patient dissatisfaction depends upon proper patient selection, and this selection process begins at the initial consultation. [AM](#)