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## PERFECTIONISM AND COSMETIC SURGERY

*Sir:*

Cosmetic surgery operations are procedures with psychological significance involving the patient's body and body image. We propose one type of pathological personality as a contraindication for cosmetic surgery procedures: perfectionism. The stringent self-evaluations, propensity for other-derogation, intense fear of scrutiny, excessive sense of entitlement, and extreme need for others' approval that characterize perfectionism make satisfied perfectionists a rarity and dissatisfied perfectionists an inevitability.[1] This chronic predisposition toward dissatisfaction is why we assert that pathological levels of perfectionism should preclude cosmetic surgery procedures.

An objective improvement in physical appearance is unlikely to ameliorate the distressing sense of deformity experienced by perfectionists, which subverts an important aim of cosmetic surgery. As with bodybuilding perfectionists who view themselves as scrawny despite their bulk or anorexic perfectionists who regard themselves as overweight despite their emaciation,[2] it is not objective physical appearance but pathological personality processes that generate, maintain, and exacerbate many perfectionistic cosmetic surgery patients' perception of deformity.

We have argued that there are three enduring perfectionism dimensions: (1) self-oriented perfectionism involves requiring perfection of oneself; (2) other-oriented perfectionism involves demanding perfection from others; and (3) socially prescribed perfectionism involves perceiving that others demand perfection of oneself. The Multidimensional Perfectionism Scale[1] measures this model, and numerous studies[1–3] have linked perfectionism to depression and profound dissatisfaction, intense anger and hostility, suicide, and body dissatisfaction, including a desire for cosmetic surgery procedures.

We believe perfectionism dimensions differentially influence individuals who seek and undergo cosmetic surgery procedures by affecting their preoperative motivations and expectations and their postoperative adjustment and satisfaction. For example, self-oriented perfectionists' unrelenting self-scrutiny, unrealistic expectations, and fault-finding predilection are likely to transform an aesthetically successful surgery into a distressing perceived failure, whereas other-oriented perfectionists' interpersonal hostility and haughty demandingness are apt to result in a conflictual, potentially litigious doctor-patient relationship. Finally, socially prescribed perfectionists are likely to pursue cosmetic surgery procedures not because of internal motivations but because they are driven by external contingencies, such as acceding to perceived expectations, responding to societal pressures, and eliciting approval from others.

Overall, cosmetic surgery procedures are unlikely to augment the deficient sense of self or to remove the pervasive feeling of inferiority that accompanies elevated levels of perfectionism.[3] There is an irreducible gap between the perfect body that perfectionists seek and the imperfect body that perfectionists perceive. Attempting to bridge that gap through cosmetic surgery alone may be ill advised.
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## THE HAZARDS OF CONTEMPORARY PARAMEDIAN FOREHEAD FLAP AND NECK DISSECTION IN SMOKERS

*Sir:*

The vascular supply to the face allows surgeons to harvest a variety of small flaps with safety. The paramedian frontal flap is arterialized medially by the supratrochlear and angular arteries and laterally by the supraorbital artery. The collecting directional veins of the frontal-supraorbital region are the supraorbital, superficial temporal, and anterior facial veins.[1]

A 36-year-old patient who smoked 30 cigarettes a day underwent nasolabial and septal resection for a highly invasive squamous cell carcinoma associated with multifocal carcinoma in situ of the nasal mucosa. Submandibular and cervical lymph node bilateral dissection was planned for 1 month later. Reconstruction was carried out at the same time as the neck dissection, before radiation therapy.

After the primary resection, the defect included the columella, the anterior septum, and the middle part of the upper lip a few millimeters above the vermilion. A paramedian forehead flap procedure was performed. The tip of the flap was a 1 × 3-cm strip of the scalp; the middle part was 2.5 cm, with 5 mm of galea at the edges; the lower part was less than 2 cm, and the pivot point was nearly 1.5 cm. The flap was elevated off the periosteum below the orbital rim. The flap covered the anterior septum and