As aesthetic surgeons and medical practitioners, we always welcome the opportunity to offer patients new treatment options that have been tested for safety and efficacy. The approval of a new formulation of botulinum neurotoxin type A (BoNTA-ABO; Dysport [abobotulinumtoxinA], Medicis Aesthetics, Scottsdale, AZ) by the US Food and Drug Administration (FDA) offers aesthetic specialists in the United States just such an opportunity. FDA approval of BoNTA-ABO is for treatment of cervical dystonia in adults and for temporary improvement in the appearance of moderate to severe glabellar lines in adults under 65 years of age.

Back in the 1980s, it would have been difficult (if not impossible) to predict that within 20 years, nonsurgical rejuvenation would be the fastest growing segment of most cosmetic practices. I am well aware that the 1980s may seem like ancient history to some readers of Aesthetic Surgery Journal. In fact, in the ‘80s—when I was a medical student, house officer, and junior attending—if a senior surgeon referred to “how we did it back in the ‘60s,” I would listen politely but usually considered the information largely irrelevant. Like many young surgeons, I held the belief that the world was different then. Today, that’s probably more true than ever, but to understand how we arrived at the point where an entire supplement of the world’s leading journal of cosmetic surgery is devoted to investigation of a single nonsurgical treatment, it is helpful to review a bit of history.

Depending on how far one wishes to go, the history of neurotoxins can be traced back decades to the findings of ophthalmologist Dr. Alan B. Scott1 or, more narrowly, to its pioneering application for aesthetic purposes in the 1990s.2 Dissatisfaction with traditional forehead surgery for rhytides was certainly part of the impetus for botulinum toxin’s rapid emergence into the aesthetic realm. The long incision required for the traditional forehead lift was distasteful, if not alarming, to many patients. Furthermore, from both the patient’s and surgeon’s point of view, results frequently were not optimal. As documented in a study that I published with Dr. Terino in 1994,3 the majority of patients seeking forehead rejuvenation did so for the treatment of glabellar and transverse forehead lines, and not necessarily to correct low brows. Conversely, the coronal or anterior browlift procedures of the ‘80s and ‘90s were relatively effective for elevating low brows, but were less effective in ameliorating rhytides caused by dynamic muscle activity, despite excising frontalis and corrugator muscles.

From the early ‘90s forward, forehead surgery arguably underwent more changes and was subject to more controversy than any other facial rejuvenation procedure. Foreheads began to be treated by endoscopic surgery,4 and the debate over appropriate fixation methods and longevity of results raged on via countless presentations and publications. Direct excision methods and transpalpebral approaches also had their vocal proponents.5 While the analysis of these and other techniques certainly advanced our understanding of anatomy, it also led to a lingering confusion regarding the “ideal” surgical treatment for browlifting and forehead rejuvenation.

This evolution of (or confusion regarding) surgical forehead lifting occurred during a time in which there was almost no such thing as nonsurgical facial rejuvenation. Basically, our repertoire of nonsurgical procedures consisted of one collagen-based filler, phenol peels, and...
and dermabrasion. These circumstances created a “perfect storm” (or at least a highly receptive environment) for the introduction of a serendipitously-discovered nonsurgical technique that easily addressed patients’ primary concern of forehead and brow wrinkles—and that did so more effectively than surgery. In fact, by the late ’90s, there was so much interest in nonsurgical rejuvenation methods—botulinum toxin, fillers, and lasers—that the first courses invariably were packed to capacity with doctors eager to learn these state-of-the-art techniques.

As we know, botulinum toxin has become statistically the most frequently performed cosmetic procedure over the last decade. Along with liposuction, botulinum toxin has produced a seminal, once-in-a-generation change in how we practice cosmetic surgery and medicine. Indeed “Botox” has entered the popular vernacular and neurotoxin injections have become an indispensable part of many people’s lives. Still, despite expanding aesthetic indications and hundreds of nonaesthetic applications for neurotoxins, there has been only one product available in the United States. Unlike the filler and laser markets, which have been virtually flooded with new products and technologies on a steady basis, the neurotoxin market in the United States has been static. That changed in April 2009 when the FDA approved this new US formulation of botulinum neurotoxin type A belonging to a family of compounds proven effective in a wide range of aesthetic and nonaesthetic areas. Outside of the United States, BoNTA-ABO is already well established, with a nearly 20-year track record.6,7

This sponsored supplement is designed to help physicians understand and evaluate the potential role of BoNTA-ABO in their cosmetic practices. As Guest Editor and on behalf of the Aesthetic Surgery Journal’s Editorial Board, I thank those involved in this timely clinical and scientific research, including the physicians (members of the Reloxin Investigational Group) who have conducted a series of randomized, controlled clinical trials that meet exacting Federal standards and the more than 3200 patients who have cooperated with these studies. While this supplement is sponsored by Medicis Aesthetics, each of the included manuscripts has undergone the same peer review process as any other paper submitted to the Journal. I want to thank all of the participating Aesthetic Surgery Journal reviewers, who were selected with great care to ensure no conflicts of interest with regard to the company or product; they have lent their considerable expertise to an unbiased evaluation of the scientific merits of this research.

Finally, I would like to acknowledge for our readers the change in Guest Editorship from what was announced in the prepublication version released in May 2009. Drs. Mark Jewell and Gary Monheit had graciously accepted an invitation to serve as coeditors of the supplement, but later recognized that their ongoing association with the sponsor—even when fully disclosed to readers—might be perceived as incompat-

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**REFERENCES**


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**DISCLOSURES**

The author has no disclosures with respect to the contents of this article.