AESTHETIC INTELLIGENCE

BY COSMEDOCS & HARLEY STREET INSTITUTE

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Recognition should follow care.

TEOSYAL OUTSTANDING CLINIC AWARD

Winner, Q2 2017

A marker of the standards behind the work - not a substitute for them.

COSMEDOCS · HARLEY STREET, LONDON

Aesthetic *Intelligence*

How to read your face before someone sells you another treatment

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Cosmedocs works with PrivaDr Ltd, 10 Harley Street, London W1G 9PF for all CQC required treatments.

For the patients who asked the better question:
not what can I have, but what do I actually need.

COSMEDOCS

AESTHETIC MEDICINE

Mostly natural.
Sometimes bold.
Never apologetic.
Always yours.

Invisible work. Visible confidence.

Contents

Read straight through—or enter where your face asks the question.

Contents

Read straight through—or enter where your face asks the question.

FIELD NOTE

Basic terms, in normal English

MEDICAL TERM	PLAIN ENGLISH
Epidermis	The outer skin layer
Dermis	The deeper support layer of the skin
Keratinocyte	Skin surface and renewal cell
Melanocyte	Pigment-producing cell
Fibroblast	Collagen-building support cell
Dynamic line	A wrinkle seen mainly when the face moves
Static line	A wrinkle that remains when the face is relaxed
Volume loss	Loss or redistribution of facial soft-tissue support
Laxity	Looseness of skin or soft tissue

THE MIRROR SIDE

THE FACE IN YOUR HEAD

The mirror updates every birthday.
The person in your head does not.

THE INTELLIGENT QUESTION

When you look in the mirror,
do you still recognise yourself?

PROLOGUE

The Face in Your Head

There is a question I sometimes ask patients that has absolutely nothing to do with filler.

How old are you when you dream?

Nobody answers immediately. They look at me as if I have slipped a psychiatric assessment into a Botox consultation and they are now trying to remember what they ticked on the medical form. But think about it. In a dream you do not normally stop to check your date of birth. You do not necessarily appear as the forty- seven-year-old version of yourself because your driving licence insists on it. You are simply you.

And I think that explains something patients have been trying to tell me for nearly twenty years.

They look in the mirror and say, “I don’t look like myself.” Obviously it is them. Unless someone has performed an unusually elaborate identity theft overnight, the person in the mirror remains legally theirs. But I know what they mean now.

The person in your head does not update itself every birthday. The mirror does.

Aesthetic medicine lives, partly, in that gap. Not necessarily make me twenty-five. More often: make the outside look a little closer to the person I

still recognise.

But before we get too excited about the face, there is another problem. The face does not travel through life independently of the body carrying it.

I occasionally meet somebody enormously concerned about three millimetres of jawline while everything else appears to have been placed on administrative leave. Haircut six months overdue. Posture collapsing. Weight fluctuating. Teeth ignored. Sleep apparently abandoned as a concept.

Then: “Can you lift this?”

Possibly. But we are decorating one room while the roof needs attention.

Aesthetic medicine should be the next level of grooming, not a replacement for grooming. Hair matters. Teeth matter. Weight and body composition matter. Posture matters enormously. The way you move into a room matters. Clothes matter. Sleep matters. Skin matters.

At twenty feet I cannot see your crow’s feet. I can see your silhouette. At five feet I begin to see your face. At two feet I see skin, expression and proportion. At one foot I can find something wrong with absolutely everybody.

So this is not a book about perfection. It is about where to look, in what order, and when to stop looking.

The face gives us four broad chapters: skin, movement, volume and support, then laxity and descent. Beautification sits slightly to one side because it is not necessarily ageing at all. It is proportion, attraction and creative choice.

If you understand those distinctions, you can walk into almost any aesthetic clinic with considerably more intelligence than the menu expects of you.

PART ONE

The Ageing Curve

Why faces change, and why the change is not gradual.

AGEING HAS GEARS

Change is gradual - until it accelerates.

THE INTELLIGENT QUESTION

Where am I on the curve?

A conceptual curve, not a personal timetable.

CHAPTER ONE

The Ageing Curve Has Gears

We like to imagine ageing as a polite little graph: one birthday, one tiny deduction. A bit less collagen this year, another wrinkle next year, and somewhere around sixty somebody hands you a cardigan.

Biology is not that considerate.

The better way to think about ageing is that it has gears. There are long stretches where change is relatively quiet, then shorter windows where several systems appear to accelerate together. A much-discussed 2024 multi-omics study reported broad molecular change clustering around the mid-forties and again around sixty. That is interesting, but the exact peak ages are still being scrutinised, so I would not tattoo 44 and 60 onto anybody's forehead. The useful idea is the non-linearity: the rate of change is not constant.

In women, the clearest example is the menopausal transition. The fall in oestrogen is associated with a genuine acceleration in skin and connective-tissue ageing. Reviews of the established literature report that as much as about 30% of dermal collagen may be lost in the first five years after menopause, followed by a slower loss of roughly 2% per year thereafter.

I call this the collagen cliff. Not because your face walks happily along and suddenly falls off Beachy Head, but because the slope can become

noticeably steeper.

That changes the question from, “What treatment do I need today?” to, “Where am I on the curve?”

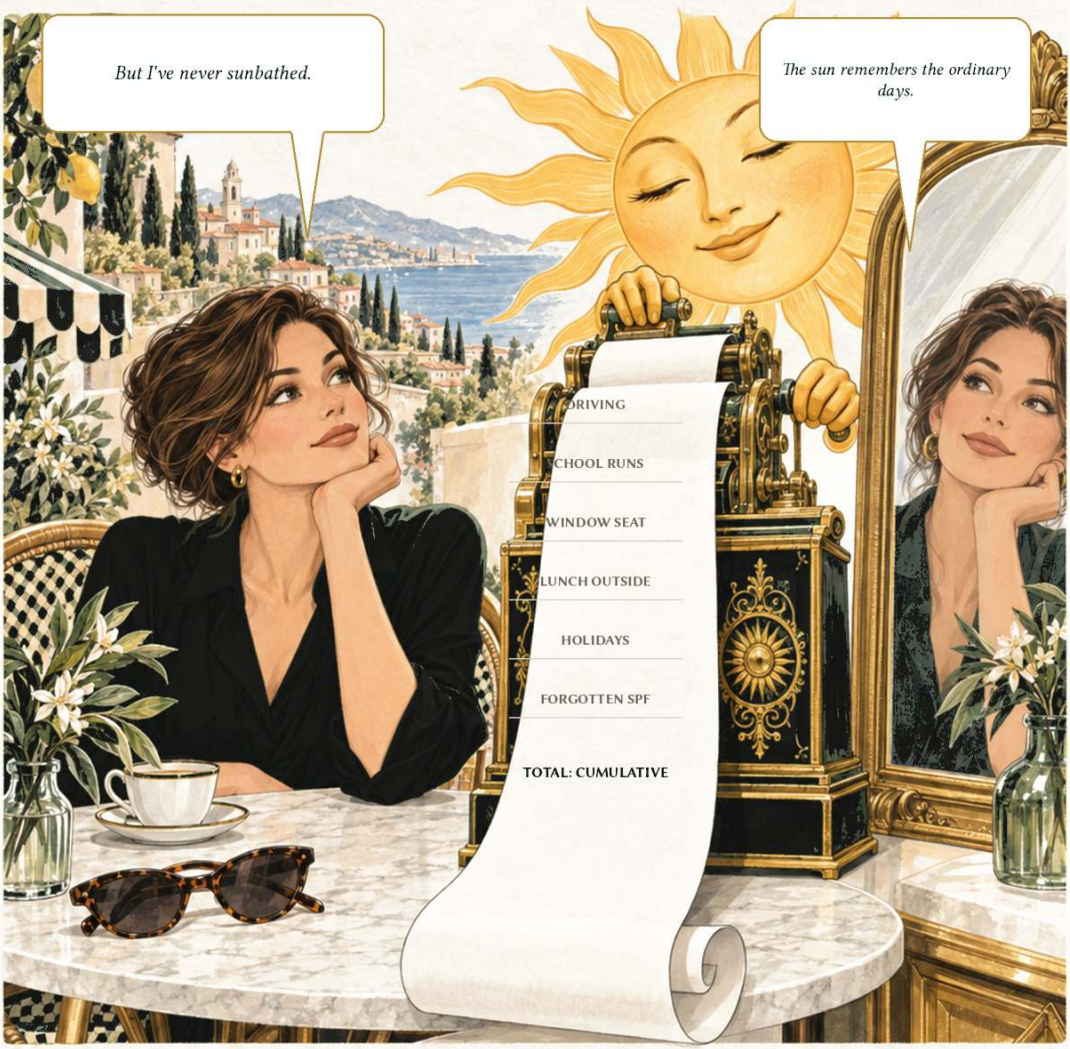
A woman of thirty-five with excellent skin may need little more than protection, antioxidant support and a sensible retinoid plan. The same woman approaching perimenopause may benefit from deliberately maintaining dermal quality before a faster loss window. Five years later, the same face may need a different combination of skin regeneration, movement control and structural support.

Age is the number on the chart. Stage is where you are on the curve.

And this is why treatment timing matters. The objective is not to panic when the biology accelerates. It is to arrive at the faster part of the road with as much tissue quality and structural reserve as reasonably possible.

THE SUN KEEPS RECEIPTS

The sun remembers the ordinary days.



What has my skin been exposed to?

Life happens outside.

CHAPTER TWO

The Sun Keeps Receipts

Another patient once told me she did not have sun damage because she had never sunbathed.

She said this while sitting twelve feet from a window.

The sun has never required a beach towel.

Most ageing skin has two biographies. Intrinsic ageing is the clock: genetics, hormones, time, cellular ageing, collagen changes, fat changes, bone changes, the normal consequences of continuing to be alive.

Extrinsic ageing is what happens to the clock while you carry it around: ultraviolet exposure, smoking, pollution, inflammation, chronic irritation, repeated habits and the occasional period of treating your body as if it were a hire car.

That distinction matters because much of aesthetic medicine is not actually reversing age. It is reversing or reducing some of the visible consequences of accumulated damage.

UV exposure encourages uneven pigment and contributes to degradation of the dermal matrix. It also adds oxidative stress. This is where antioxidants enter the story, which is the point where the beauty counter normally becomes very excited.

The Winter-Sun Problem

Summer is a season. UV is a habit.

Vitamin C can help with antioxidant support, pigment regulation and collagen biology. But the words VITAMIN C on the front of a bottle tell you less than you think: form, concentration, stability, packaging and tolerance all matter.

6 DAYS OF WINTER SUN

≈ 43%

of an indoor worker's annual UV dose

In one monitored study of northern-European sun-seekers in the Canary Islands, six days delivered an average 57 standard erythema doses—43% of a Danish indoor worker's annual UV dose. A short winter holiday can carry a surprisingly large share of the year's exposure.

Retinoids do not automatically need a three-month summer holiday. When appropriate for the patient, they can often continue with adjusted frequency, a calm barrier and rigorous photoprotection. Pause for irritation, intense exposure, procedures, pregnancy or clinician advice—not because the calendar says June.

Source: Petersen et al., British Journal of Dermatology, 2013;168:1073–1079.

CLINICAL SECTION

Skin Assessment

Read the face before choosing the treatment.

Understand the four domains. See a worked example. Then score your own face.

SKIN · MOVEMENT · VOLUME & SUPPORT · LAXITY & DESCENT

Beautification is a separate question - not every difference is ageing.

ARTICLE

Ageing Is Not One Thing

There are four tissues in a face and each of them ages at its own speed. Almost every disappointing result comes from treating the wrong one.

If you ask somebody what ageing looks like, they will usually describe skin. Fine lines, dullness, a crepey patch near the eye. Skin is what we can see, so skin is what gets blamed.

But a face is built in layers, and the layers do not deteriorate in step with each other. There are four that matter clinically.

SKIN

The envelope. It thins, loses elasticity, accumulates pigment and sun damage, and slows its own repair. This is the layer that responds best to consistent, unglamorous care over years — photoprotection, retinoids where tolerated, and treatments that ask fibroblasts to work rather than forcing the surface to peel.

FAT

The part almost nobody thinks about, and the part responsible for most of what patients actually dislike. Facial fat is not one soft mass. It sits in compartments, and those compartments do not shrink evenly. Some deflate — the temple, the mid-cheek, the area under the eye. Others persist and descend, which is why a face can look simultaneously hollow

FIELD NOTE

The face in four domains

DOMAIN	QUESTIONS TO ASK	TYPICAL CATEGORIES
Skin	Is it texture, colour, barrier or vitality?	Skincare, peels, microneedling, selected regenerative / skin-quality approaches
Movement	Does it appear mainly during expression or compensation?	Botulinum toxin and other cause-specific management
Volume & support	Has contour, projection or support changed?	Conservative filler / structural restoration where indicated
Laxity & descent	Has tissue genuinely loosened or moved?	Skin-quality work, selected energy treatments, surgery when the nonsurgical ceiling is reached
Beautification	Is this ageing - or a proportion the patient has always wanted different?	Chin, lips, nose, jaw, cheek / profile work based on individual harmony

Diagnose the domain before choosing the treatment.

Beautification is a separate question: ageing is not the same as proportion.

and heavy. This is a strange sentence until you have seen it a thousand times.

MUSCLE

Muscle shortens with repetition. Decades of the same expression, the same squint, the same concentration frown, and the muscle sets shorter and pulls harder. The line above it is a consequence, not the problem itself.

BONE

The scaffolding, and the layer people assume is permanent. It is not. The bone around the eye socket widens. The jaw and the mid-face lose projection. When the scaffolding retreats, everything mounted on it has further to fall and less to sit on.

So the useful question is never "what treatment do I need?" It is "which layer changed?" Skin treatments do not fix deflated fat. Filler does not shorten a muscle. Neither of them rebuilds bone. The result you want depends entirely on getting that identification right before anybody opens a needle.

This is also why two people of the same age can need almost nothing in common. One has excellent volume and badly sun-damaged skin. The other has flawless skin sitting on a face that has quietly lost a third of its mid-face support. Same birthday. Completely different plan.

Worked example. The same patient, one year apart, scored on the HSI Mini Facial Scale opposite. Photographed in identical lighting and position.

CLINICAL WORKED EXAMPLE

Reading a face, then scoring it

HSI MINI FACIAL SCALE — ANTIAGEING	BEFORE	AFTER	CHANGE
Skin Surface (0-3)			
Pore size & congestion	1	1	0
Colour changes	1	1	0
Hydration	1	1	0
Roughness	1	1	0
Sensitivity	0	0	0
Static Lines (0-4)			
Frown	0	0	0
Forehead	0	0	0
Crow's feet	0	0	0
DAO (sad expression lines)	0	0	0
Bunny lines	0	0	0
Oral commissure	1	0	-1
Mentalis crease	3	1	-2
Volume & Structure (0-3)			
Temples	1	0	-1
Cheeks	2	1	-1
Nasolabial	2	0	-2
Chin	2	0	-2
Jawline	3	1	-2
Marionette	2	1	-1
Lips	1	1	0
Tear trough	1	1	0
Skin Laxity (0-3)			
Jawline laxity	1	1	0
Eyebrow hooding			—
TOTAL	**23**	**11**	**-12**

Previous upper-face botulinum toxin, so the static-line domain is already controlled at baseline.

YOUR TURN

Score your own face

Score each item from 0 (not present) upward. Before, then again at review.
There are no wrong answers — this is how you and your doctor agree what matters.

NAME _____ DATE _____

HSI MINI FACIAL SCALE — ANTIAGEING	BEFORE	AFTER	CHANGE
Skin Surface (0-3)			
Pore size & congestion			
Colour changes			
Hydration			
Roughness			
Sensitivity			
Static Lines (0-4)			
Frown			
Forehead			
Crow's feet			
DAO (sad expression lines)			
Bunny lines			
Oral commissure			
Mentalis crease			
Volume & Structure (0-3)			
Temples			
Cheeks			
Nasolabial			
Chin			
Jawline			
Marionette			
Lips			
Tear trough			
Skin Laxity (0-3)			
Jawline laxity			
Eyebrow hooding			
TOTAL			

A falling total is the result. A lower number, not a different person.

CLINICIAN USE

One page. Tick, then prioritise.

Tick only where clinically appropriate. Write 1, 2, 3 in the priority box — blank is a decision.

P = PRIORITY ☐ = SUITABLE

MOVEMENT — BOTULINUM TOXIN

- ☐ ☐ Forehead lines
- ☐ ☐ Frown lines (glabella)
- ☐ ☐ Crow's feet
- ☐ ☐ Brow lift (chemical)
- ☐ ☐ Bunny lines
- ☐ ☐ Gummy smile
- ☐ ☐ Lip flip
- ☐ ☐ Chin (mentalis) dimpling
- ☐ ☐ Nefertiti neck & jaw lift
- ☐ ☐ Masseter / jaw slimming
- ☐ ☐ Bruxism & clenching
- ☐ ☐ Migraine protocol
- ☐ ☐ Hyperhidrosis
- ☐ ☐ Facial blushing
- ☐ ☐ Trap Botox

VOLUME & SUPPORT — DERMAL FILLERS

- ☐ ☐ Lips
- ☐ ☐ Cheeks / midface
- ☐ ☐ Tear trough
- ☐ ☐ Chin
- ☐ ☐ Jawline
- ☐ ☐ Temples
- ☐ ☐ Nasolabial folds
- ☐ ☐ Marionette lines
- ☐ ☐ Non-surgical rhinoplasty
- ☐ ☐ Neck lines
- ☐ ☐ Earlobe rejuvenation
- ☐ ☐ Dissolving (Hyalase)

LAXITY & DESCENT — LIFTING

- ☐ ☐ Nefertiti Botox lift
- ☐ ☐ Liquid facelift (HA makeover)
- ☐ ☐ PDO mono threads
- ☐ ☐ PDO cog thread lift
- ☐ ☐ XL Endolaser fibre lift
- ☐ ☐ Neck & submental tightening
- ☐ ☐ Jawline & jowl contouring

SKIN QUALITY — REGENERATIVE

- ☐ ☐ Profhilo
- ☐ ☐ Polynucleotides
- ☐ ☐ Sunekos 200
- ☐ ☐ Jalupro
- ☐ ☐ Lumi Eyes
- ☐ ☐ Exosomes
- ☐ ☐ PRP
- ☐ ☐ Microneedling
- ☐ ☐ Chemical peel
- ☐ ☐ HydraFacial
- ☐ ☐ PP Glow

SKIN & HAIR MEDICINE

- ☐ ☐ Prescription skincare plan
- ☐ ☐ Acne programme
- ☐ ☐ Pigmentation / melasma
- ☐ ☐ Rosacea programme
- ☐ ☐ Scar reduction
- ☐ ☐ ScarTox scar repair
- ☐ ☐ Fat dissolving
- ☐ ☐ Hair loss assessment
- ☐ ☐ Hair transplant referral
- ☐ ☐ Laser hair removal

DIAGNOSIS FIRST — DERMATOLOGY

- ☐ ☐ Acne & breakouts
- ☐ ☐ Eczema & dermatitis
- ☐ ☐ Mole / lesion check
- ☐ ☐ Skin biopsy or referral

SURGICAL CEILING — PLASTIC SURGERY

- ☐ ☐ Blepharoplasty
- ☐ ☐ Facelift surgery
- ☐ ☐ Rhinoplasty
- ☐ ☐ Liposuction
- ☐ ☐ CO2 laser resurfacing
- ☐ ☐ Surgical opinion only

The face should determine the treatment.
The treatment should never determine the face.

PART TWO

Skin First

Every honest assessment begins at the surface, because the surface is the only part you can see.

THE SKINCARE BAR

A bottle for every concern - including the ones you did not know you had.

RETINOL | VITAMIN C | PEPTIDES | AHA | BHA | NIACINAMIDE | CERAMI

DR HAQ

"Instagram did not invent vanity. It gave it a drinks trolley and sped up the service. One serum became a routine, the routine became a cabinet, and perfectly sensible people became cosmetic junkies - getting their skin drunk on products it never asked for."

CHAPTER THREE

The Cosmetic Junkie

She was twenty-three, beautiful, and wearing enough makeup to survive minor structural damage.

She had come because her skin looked dull, which presented an immediate diagnostic problem because I could not actually see any of it.

Foundation, concealer, powder, primer, something luminous over something matte, all held together by a setting spray that appeared to have been developed for maritime conditions.

“Can you take the makeup off?”

She looked at me as though I had asked her to remove a small organ.

“All of it?”

“Ideally I’d like to examine you rather than Estée Lauder.” Eventually it came off. Underneath was not bad skin. It was young skin having a bad time: congestion, uneven colour, some inflammation, a slightly rough surface, and enough product residue to suggest the bathroom had its own procurement department.

Then she showed me a photograph of her dressing table.

I stopped counting at twelve products. Two cleansers, a toner, an essence, three serums, moisturiser, oil, sleeping mask and something described as a

THE GOLD-DUSTING TRICK

Around fifty years ago, the sales lesson was already clear:

SCIENCE SELLS.

Business lesson, paraphrased; see Harvard Business School's Olay case.

GOLD ON THE FRONT.

DUST NEAR THE BOTTOM OF THE BACK.

An ingredient name is not its strength, stability, pH or delivery system.

The label tells a story. The formula has to do the work.

Below 1%, ingredients may be listed in any order. Read the claim and the evidence too.

cellular activating ferment. There may have been more. The photograph ended before the furniture did. Nobody chooses to become a cosmetic junkie. It happens politely. One product for dullness. Another for pores. Something for hydration. Something for “repair”. A friend recommends an acid. An influencer recommends a peptide. A sales assistant discovers a concern you had not realised you owned. You do some independent research at midnight, which in 2026 usually means three tabs, two reels and a stranger with excellent lighting. Nothing feels irrational at the moment of purchase. That is how the dressing table grows.

And this is not confined to people who know nothing about medicine. I have seen versions of the same shelf belonging to nurses, female doctors and, slightly more embarrassingly, aesthetic practitioners. Someone can explain renal physiology from memory and still own four moisturisers whose collective purpose nobody can identify.

Knowing ingredient names is not the same as understanding a clinical skin plan. The mistake is learning products before learning skin.

For patients, I reduce the visible problem to three cells. Dermatologists can relax; I know there are more. The simplification is deliberate.

The keratinocyte is, in normal English, a skin-surface and renewal cell. It helps form the epidermal barrier and ultimately becomes part of the outer layer that is shed. The melanocyte is the pigment-producing cell. Beneath them, in the dermis, the fibroblast is one of the important collagen-building support cells. Texture. Colour. Vitality.

Those three words explain a remarkable amount of what people mean when they say their skin no longer looks healthy.

The closest many of us ever come to genuinely effortless “flawless” skin is childhood, before puberty changes the biological weather. This is not a claim that every eleven-year-old has perfect skin; eczema, birthmarks, genetic conditions and childhood disease clearly exist. But pre-pubertal skin

The Minimum Effective Routine

Two actives. Everything else should earn its place.

AM / VITAMIN C

DOES YOURS CONTAIN C + E + FERULIC?

L-ascorbic acid needs an acidic formula to penetrate. On dry or unaccustomed skin, a brief tingle can be normal; persistent burning is not. Vitamin E and ferulic acid help stabilise the formula and strengthen its antioxidant performance.

Finish with an SPF you will actually wear.

PM / RETINOL

Encapsulated retinol releases slowly, so it is usually far less irritating. In a formula already packed with ceramides, lipids and humectants, many skins need no separate moisturiser.

ONE SIDE TREATED / ONE SIDE UNTREATED

SERUM + SPF IN THE MORNING. RETINOL AT NIGHT.

Cleanser? Choose what suits you.

If your skin already feels comfortable, how much more water do you bloody need?

What Is a Free Radical?

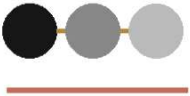
An unstable molecule with an unpaired electron - looking for company.

1 UV ENERGY

Sunlight can generate reactive oxygen species in skin.

2 FREE RADICAL

It is unstable because one electron is unpaired.



3 ELECTRON THEFT

It steals an electron from lipids, proteins or DNA - starting a chain reaction.

FREE RADICAL + ANTIOXIDANT -> STABLE

The antioxidant donates an electron without becoming dangerously reactive.

ALREADY IN YOUR SKIN

Enzymes and antioxidants form the native defence team:
SOD | catalase | glutathione
vitamin C | vitamin E

APPLIED TOPICALLY

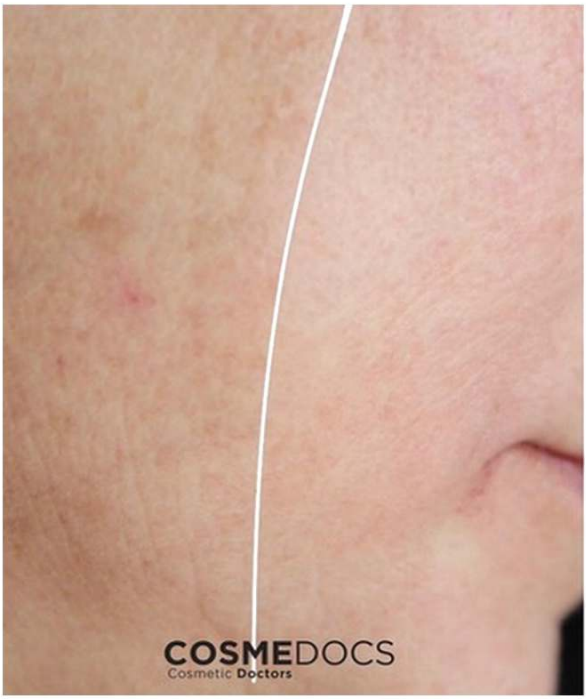
A well-formulated antioxidant serum can add support at the surface:
vitamin C + vitamin E + ferulic acid

SPF REDUCES THE HIT. ANTIOXIDANTS HELP MOP UP WHAT GETS THROUGH.

One supports the other. Neither makes deliberate sun exposure sensible.

Retinol: The Long Game

Small nightly signals. Cumulative visible change.



ONE SIDE TREATED / ONE SIDE UNTREATED

Original clinical image supplied by Cosmedocs.

WHAT IT DOES

Improves surface-cell turnover, supports collagen and gradually softens uneven tone, texture and fine lines.

WHEN YOU NOTICE IT

Weeks 1-4: adaptation.
Weeks 8-12: texture and brightness.
Months 3-6: photoageing and fine lines increasingly improve.

START SLOW

Use a pea-sized amount at night, two or three nights weekly, then build according to tolerance. More is not faster.

THE ADJUSTMENT PERIOD

Mild dryness, tightness or flaking can occur. Irritation is not proof that it is working: reduce frequency if discomfort persists.

RETINOL AT NIGHT. SUNSCREEN IN THE MORNING.

Avoid during pregnancy. Seek clinical advice for very sensitive, inflamed or reactive skin.

Consistency changes skin. Punishment merely irritates it.

has usually accumulated very little ultraviolet damage, little or no acne history and fewer years of inflammation, cosmetics and human interference.

Then adolescence arrives. Sebaceous glands become more active. Oil production changes. Follicles block. Acne appears in some people. Inflammation leaves pigment behind. Makeup enters the bathroom. Sun exposure accumulates. The face becomes an organ we actively manage rather than something we merely wash because our parents told us to.

Adult flawless skin therefore does not mean airbrushed, poreless or eleven years old. It means the basic systems are functioning well: sensible turnover, an intact barrier, controlled inflammation, even pigment and good dermal support.

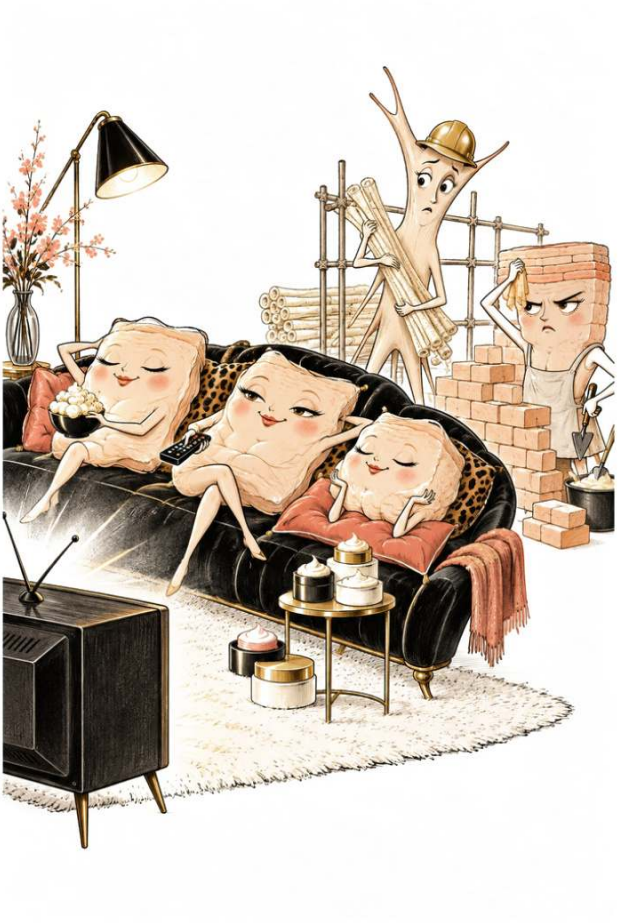
This is where I use another phrase: Lazy Skin Syndrome.

It is not a formal dermatological diagnosis. Your skin has not joined a union and refused overtime. It is a useful clinical shorthand for a pattern I see repeatedly: ever-richer moisturising, ever-more products, dull surface build-up, congestion and a growing belief that the next jar will repair what the previous eleven have failed to understand.

The science is more nuanced than the phrase. Moisturisers do not universally make skin “lazy”, and some are essential in eczema, xerosis, rosacea and damaged barriers. Different moisturiser formulations can have very different effects on barrier function; some strengthen it while others may worsen transepidermal water loss or irritant susceptibility. So the lesson is not “moisturiser is bad”. The lesson is that composition and indication matter. In my routine, moisturiser is therefore not an automatic ceremonial extra simply because every skincare diagram traditionally has one. If the cleanser, antioxidant, sunscreen or retinoid vehicle already gives the skin enough humectancy and barrier support, I do not add another jar merely because the shelf looks emotionally incomplete. If the skin is dry, barrier- impaired, eczematous, irritated or simply needs more support, then

Lazy Skin Syndrome

Your skin has not joined a union.



NO, YOUR SKIN IS NOT ON THE SOFA WATCHING FILMS.

It is a joke, not a diagnosis.

The useful question is whether the routine supports normal turnover - or simply keeps adding jars.

of course we add or choose appropriate moisturising ingredients.

What I do want almost everyone to understand is the baseline architecture.

Morning: wash, antioxidant, sunscreen.

Evening: wash, then an appropriate retinoid programme when suitable.

That is the skeleton. Not twelve steps. Not a beauty advent calendar.

The antioxidant helps with oxidative stress and, depending on the ingredient, pigment and collagen biology. Sunscreen reduces avoidable ultraviolet damage. The retinoid family supports renewal, pigment control and dermal remodelling. In sensitive skin we do not abandon the biology; we adjust the molecule, vehicle, strength, frequency and barrier support. Some patients with active rosacea, severe irritation, pregnancy or other contraindications need a different route entirely. A clinical plan is allowed to think.

Then we customise only when the skin gives us a reason.

Pigmentation? Add clinician-selected pigment suppression and tighten photoprotection.

Acne? Add acne-specific treatment; antibiotics are reserved for appropriate inflammatory disease and should be used as part of a proper medical strategy, not sprinkled into skincare forever. Rosacea? Calm inflammation, protect the barrier, avoid unnecessary irritation and use condition-specific therapy. Scarring? Control active disease first, then discuss peels, microneedling, subcision, energy or other scar-directed work according to the scar.

The baseline stays simple. The additions earn their place. Our twenty-three-year-old did not need another moisturiser. She needed subtraction, controlled exfoliation, photoprotection and a routine in which every bottle could explain its job.

A few months later she came back wearing almost no foundation. “You forgot your makeup.”

“No.”

She smiled. “I just don’t need as much.”

That was the result I liked.

Makeup is brilliant decoration. It becomes something else when you no longer feel able to show the face underneath it. The goal was never to make her anti-makeup. It was to give her the choice back.

Three cells: the simplest useful map of skin

CELL	IN NORMAL ENGLISH	WHAT YOU NOTICE	WHAT WE DO ABOUT IT
KERATINOCYTE	Skin surface and renewal cell	Texture, roughness, congestion, barrier	Cleansing, controlled exfoliation, retinoid-type support, barrier care
MELANOCYTE	Pigment-producing cell	Colour, uneven tone, post-inflammatory marks	Photoprotection, antioxidants, clinician-selected pigment control
FIBROBLAST	Collagen-building support cell	Vitality, firmness, resilience	Retinoids, microneedling, PRP, HA skin-quality treatments, polynucleotides, selected devices

THE MEMORY MAP

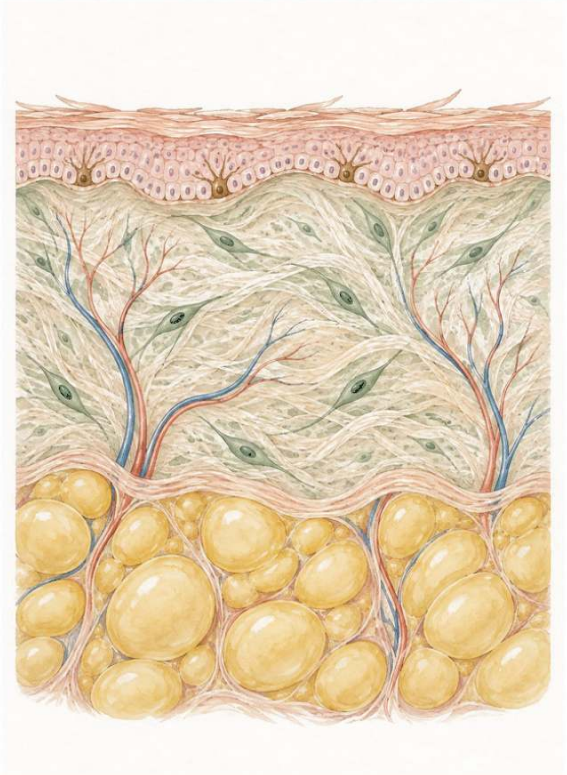
KERATINOCYTE	*Texture*
MELANOCYTE	*Colour*
FIBROBLAST	*Vitality*

EPIDERMIS -> DERMIS

Texture. Colour. Vitality. Three cells make the basic map easy to remember.

Three Layers. Different Problems.

Treat the layer that is failing—not the word on the brochure.



EPIDERMIS

Keratinocytes · melanocytes

Barrier leak · roughness · uneven pigment · melasma

DERMIS

Fibroblasts · collagen · elastin · vessels

Fine lines · thinning · redness · loss of resilience

FAT

Adipocytes · facial fat compartments

Hollowing · shadow · descent · loss of support

FIELD NOTE

Skin treatment ladder: foundation before fashion

LEVEL	TYPICAL TOOLS	MAIN JOB
Foundation	Photoprotection, antioxidants, retinoid-type care, barrier support	Prevention, turnover, pigment and long-term dermal support
Resurfacing	Peels	Texture, superficial pigment, controlled renewal
Controlled repair	Microneedling	Collagen induction, texture, scars in selected patients
Autologous support	PRP	Repair signalling and selected dermal support
Skin-quality injectables	Profhilo / Sunekos-type formulations	Hydration, elasticity, early crepiness — not structural filler
Regenerative support	Polynucleotides	Gradual tissue-quality support in selected skin
Emerging adjuncts	Exosome-based treatments	Potential signalling / recovery support; evidence and products remain heterogeneous

The base matters most. More expensive and newer does not automatically mean more appropriate.

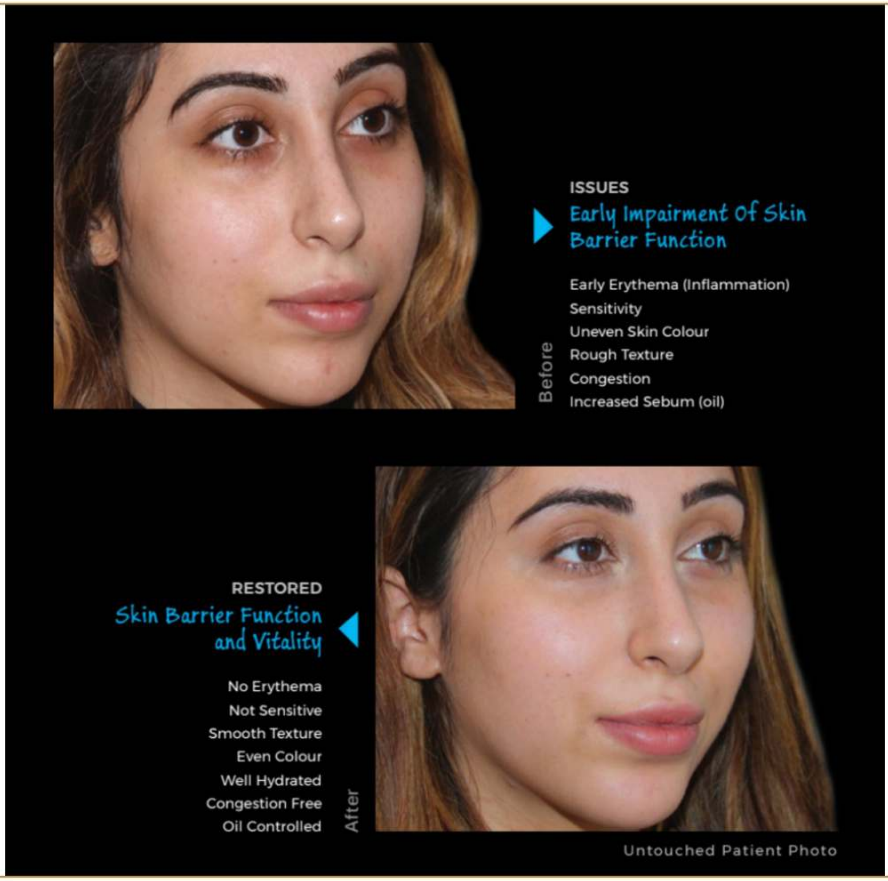
FIELD NOTE

Customise only when the skin gives you a reason

PROBLEM	WHAT CHANGES FROM BASELINE	IMPORTANT PRINCIPLE
Pigment / melasma tendency	Stronger photoprotection + clinician-selected pigment suppression	Control pigment without creating inflammation that makes pigment worse
Acne	Condition-specific comedolytic / anti-inflammatory treatment; antibiotics only when indicated	Treat active disease before scars; avoid indefinite antibiotic skincare
Rosacea / reactive skin	Barrier-first choices + condition-specific anti-inflammatory therapy	Sensitive skin still needs protection and renewal, but intensity must be adapted
Dry / barrier-impaired skin	Add or choose moisturising / barrier-supporting vehicles	Moisturiser is treatment when the barrier needs it, not a compulsory decorative step
Scarring	Control active disease, then scar-specific procedures	Different scars need different tools

Read the Barrier First

Healthy-looking skin is not the same as healthy function.



The surface was signalling barrier impairment. The plan was not 'more active ingredients'; it was to restore function, then build vitality. Calm first. Correct second. Polish last.

ARTICLE

What a Skin Assessment Actually Looks At

Five things, in order. Each one either rules a treatment in or rules it out, and no product should be chosen before all five are known.

Patients often arrive with a product list and hope I will approve it. I would rather look at the skin first, because a skin assessment is not an opinion about brands. It is five observations, and each one carries a consequence.

ONE · BARRIER

Is the skin holding water, or is it leaking? Tightness, stinging, flaking and that peculiar sensation of needing moisturiser again by lunchtime all point the same way. A compromised barrier rules out almost everything active until it is repaired. Treating a leaking barrier with acids is like sanding a wall that has damp behind it.

TWO · PIGMENT

Is the colour even, and if not, is the pigment epidermal, deeper, or inflammatory in origin? This distinction decides whether pigment will respond quickly, respond slowly, or worsen with heat and aggressive treatment. Melasma in particular punishes enthusiasm.

A Routine Is a Pyramid

Daily consistency does the heavy lifting.

The base is routine. The top is optional.

THREE · TEXTURE AND PORE QUALITY

Roughness, congestion, scarring, the way light behaves across the cheek. Texture responds to controlled injury — microneedling, appropriately chosen peels, resurfacing — but only once the barrier and pigment picture allow it.

FOUR · VITALITY

Colour, glow, recovery speed after a spot or a scratch. This reflects fibroblast behaviour and dermal support rather than anything the surface can be persuaded to do. It is the domain of bio-remodelling and regenerative treatment, not of another serum.

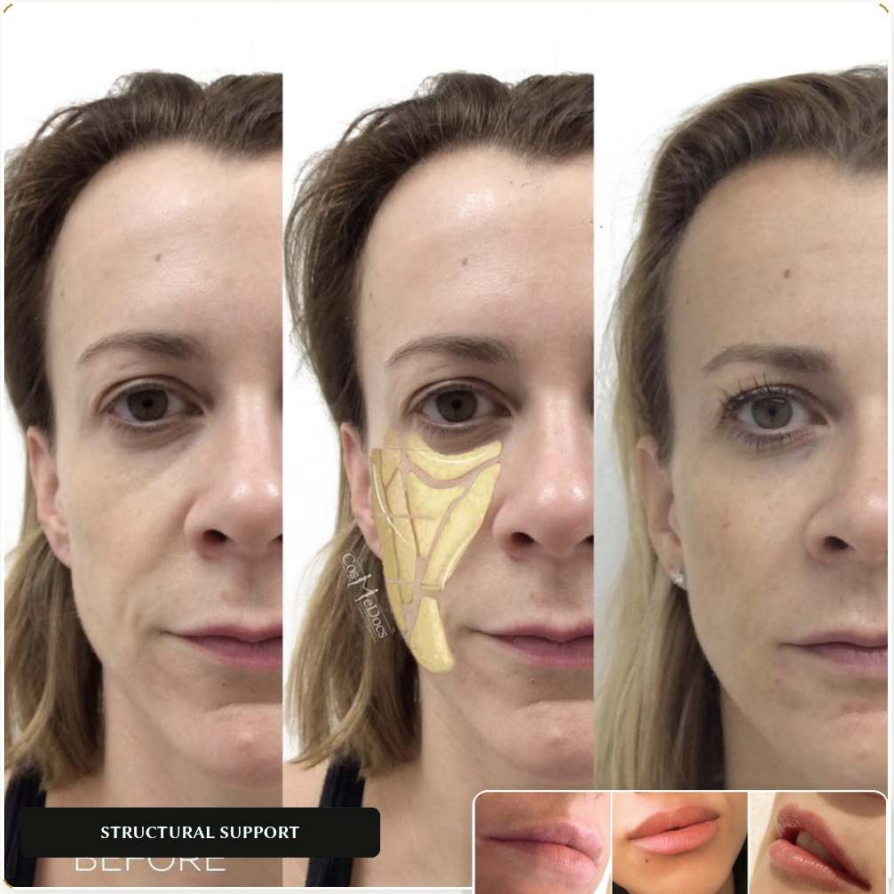
FIVE · LAXITY

How the skin sits and where it moves. Crucially, this is the point at which the assessment stops being about skin at all, because most of what looks like loose skin is not a skin problem. That is the subject of the next section.

The baseline stays simple. Cleanse, protect, and one active if the skin has earned it. We customise only when the skin gives a reason, and the reason has to come from one of these five findings — not from a bottle somebody was shown on the internet.

Volume is not one thing.

It can restore support - or refine one feature.



Replace what is missing. Preserve what still belongs to the face.

Good volume should improve the story without becoming the story.

PART THREE

Volume and Lifting

What is actually missing, what is actually descending, and why the two are treated differently.

THE APPLE

Skin is the peel. Volume is the fruit.

SURFACE ENVELOPE

EPIDERMIS + DERMIS

Thickness varies by facial site; together, roughly up to 2 mm.

DEEPER VOLUME

THE YELLOW FLESH

Fat compartments and structural support. Deflation changes the shape from underneath.

THE 2 MM PROBLEM

Skin firming can improve the peel. It cannot refill the fruit.

When a high-street 'tightening' treatment is sold as a replacement for lost volume, the promise is targeting the wrong layer.

Conceptual analogy, not to scale. Facial skin thickness varies by site.

Anatomical thickness reference: Chopra et al., Aesthetic Surgery Journal, 2015.

CHAPTER FIVE

The Apple

The single most useful thing I can explain to a patient in a consultation has nothing to do with skin, and takes about forty seconds.

Take an apple. Fresh, firm, unremarkable.

Leave it in a warm room for a fortnight and come back. It is smaller. The surface has gone slack and finely wrinkled, and where it once curved outwards it now dips inwards. Nothing has been removed from it. Nobody has damaged the peel.

The peel is loose because there is less apple inside it.

That is the whole thing. That is what most of facial ageing is.

When somebody looks at a photograph from a decade ago and cannot name what has changed, they are almost always looking at this. The temple has flattened. The area beneath the cheekbone has stopped being a smooth continuous curve and become a shadow. The eye socket looks a little larger. The corner of the mouth has begun to turn down. And the skin — the peel — has been left to cover a slightly smaller structure than the one it was made for.

Patients say, "my skin has lost volume." Skin does not really lose volume. Skin thins and loses quality, which is a separate problem worth treating on its own terms. But the hollow, sunken, deflated appearance is

the yellow part of the apple. In a face, the yellow part is fat, sitting in compartments, supported by bone that is itself quietly retreating.

WHY THIS MATTERS COMMERCIALLY

Because if you believe the problem is the peel, you will buy peel treatments. And there is an entire industry very happy to sell them to you.

A device that tightens skin is not a fraud. It genuinely does what it says. It will contract and stimulate the outer few millimetres of tissue and, in the right patient, improve skin quality visibly. I have no argument with that.

My argument is with the word lifting. Tightening the peel of a shrunken apple does not restore the apple. You can shrink-wrap it beautifully and it is still a small apple in a tight skin. Nothing has been lifted, because lifting requires either something to push from beneath or something to hold from above — and the first two millimetres of skin can do neither.

A hollow is an appearance, not a diagnosis. Before treating one, the question is always: is this less volume, or is this the same volume in the wrong place? The answer changes everything that follows.

So the plan splits in two. Where volume has genuinely gone, it needs replacing — carefully, in the correct plane, and never completely, because a face that has been fully re-inflated stops looking like the person and starts looking like a category. Where tissue has descended rather than disappeared, it needs support and repositioning, which is a mechanical problem requiring a mechanical answer.

Most faces over forty are a combination of both, in different proportions in different zones. That is why there is no single treatment, and why anybody offering you one machine as the answer to your face is describing their equipment, not your anatomy.

Look at the corner of the lip.

Restoring support can create the appearance of lift.

VOLUME REPLACEMENT TREATS LOSS

THE LIFT IS A CONSEQUENCE

The lip corner and lower face move upward as structural support is restored. A surface device cannot replace missing volume.

Clinical photography supplied by Cosmedocs. Individual results vary.

ARTICLE

Why We Do Not Own a Skin-Tightening Machine

An honest account of what surface devices achieve, what they do not, and why Cosmedocs has never offered them.

This is one of the few things about the clinic that patients occasionally challenge. Every clinic on the street seems to have a tightening platform. We have never bought one. Not because the technology is dishonest, but because of simple physics.

To change the structural behaviour of a face you have to deliver energy to the layer where the structure lives — the deep dermis and the tissue beneath it. A device working from the outside has to send its energy through the surface to get there. Which creates a hard limit: the skin is in the way, the skin is the part that burns first, and so the power has to be kept low enough to keep the surface safe.

That limit is not a flaw in any particular brand. It applies to all of them. It means a surface device can deliver only a fraction of the energy required, and it deposits most of it in exactly the layer that was never the problem.

WHAT THEY DO ACHIEVE

Genuine, measurable improvement in skin quality. Some contraction. Some collagen stimulation. In a younger patient with good volume and early laxity, a visible tidying of the surface. That is a real result and I would not pretend otherwise.

WHAT THEY DO NOT ACHIEVE

Lift. Repositioning of descended tissue. Restoration of lost volume. Any change in the deeper support that determines the shape of a jawline or a mid-face.

The problem is not the machine. It is the gap between what it does and what it is sold as doing. A patient books a course of six, spends a considerable sum, sees her skin look slightly better and her jawline look exactly the same, and concludes that nothing works. She then arrives in my room believing she needs a surgeon, when in most cases she needed a different tool three years ago.

If a device could truly lift a face from the surface, we would have bought one years ago and said so loudly. We have not, because it cannot, and I would rather explain the physics than sell the course.

ARTICLE

What We Use Instead

Threads that hold, threads that improve tissue quality, and a laser that works from underneath the skin rather than through it.

Having declined the surface device, I am obliged to say what we do use. There are three tools, and they do different jobs.

MONO THREADS

Fine, smooth, absorbable polydioxanone threads placed in a grid through the tissue. They have no hooks and they are not designed to pull anything. Their job is quality: a controlled stimulus that recruits fibroblasts and, over the following weeks, leaves the tissue firmer and better supported than it was. This is the quiet, unspectacular part of the work, and it is often what makes everything else look better.

COG THREADS

The same absorbable material, but with small barbs cut or moulded along its length. Those tiny hooks engage the tissue, which allows it to be repositioned and held in a slightly better place while the body builds its own collagen scaffold around the thread. This is mechanical lift, achieved mechanically. It is the honest answer to descended tissue, and it is why we can talk about lifting without misusing the word.

ENDOLASER

The most important difference in the clinic. Instead of firing energy through the skin from outside, a micro-fibre is passed beneath the skin and the energy is delivered directly into the deep tissue where the structure lives.

This inverts the physics described in the previous article. There is no surface in the way, so there is no need to keep the power low to protect it. We can deliver a substantial amount of energy exactly where contraction and remodelling are useful — far more than any external device could deliver without burning the skin it has to pass through. In appropriate patients the fibre also addresses small deep fat deposits, which is a form of contouring no cream and no surface platform will ever manage.

Same intention, opposite direction. A surface device tries to reach the structure through the skin. A fibre starts at the structure and leaves the skin alone.

None of these three is a whole plan by itself. They combine — quality, support, deep remodelling — and they combine with volume, which is the subject of the next article.

The finger test. If lifting the skin at the jaw makes the shadow disappear, the finding is descent and lost support — not excess fat, and not a skin problem.

CHAPTER SIX

The Finger Lift

Every aesthetic doctor knows the gesture.

Finger beside the ear. Pull.

Sometimes two fingers. Occasionally both hands, which moves enough tissue to qualify as temporary relocation.

“There. I want this.”

No, you do not.

If I actually made you look like that permanently, you would sue me.

But I never stop patients doing it because the finger is useful. It shows the wish.

It does not show the diagnosis.

The patient may be looking at a nasolabial fold, a jowl, a heavy mouth corner, a tired cheek. She pulls everything backwards and assumes the problem is loose skin.

Faces do not age like old bedsheets.

Skin changes. Fat compartments change in different ways. Bone remodels. Muscle influences the surface. Ligamentous and fascial support matters. Volume may reduce in one place, remain in another, or become more

visible because its neighbours have changed.

So a hollow is an appearance. Not a diagnosis.

A tear trough can become more obvious because the cheek beneath it has changed. A nasolabial fold can deepen because of anatomy, movement and support. A jowl can reflect descent, pre- jowl structure, skeletal projection, fat, skin and muscle. Yet the patient points at the line. Naturally. That is where the problem is visible.

A practitioner should be able to look at the line and ask what created it.

Not what can I inject into it.

This is why one of my favourite rules is that anatomical ageing is not the same thing as treatment target.

The ageing change can be deep and the useful treatment superficial. Or the visible complaint can be superficial and the driver structural. The face does not issue treatment priorities according to anatomical depth.

This is also where the word lift becomes dangerous. “Lift”, “tighten” and “firm” are marketing words until somebody identifies which tissue is being treated and what magnitude of movement is actually realistic.

A device can improve selected laxity. It cannot reproduce a surgical facelift because the patient pulled hard enough in the mirror.

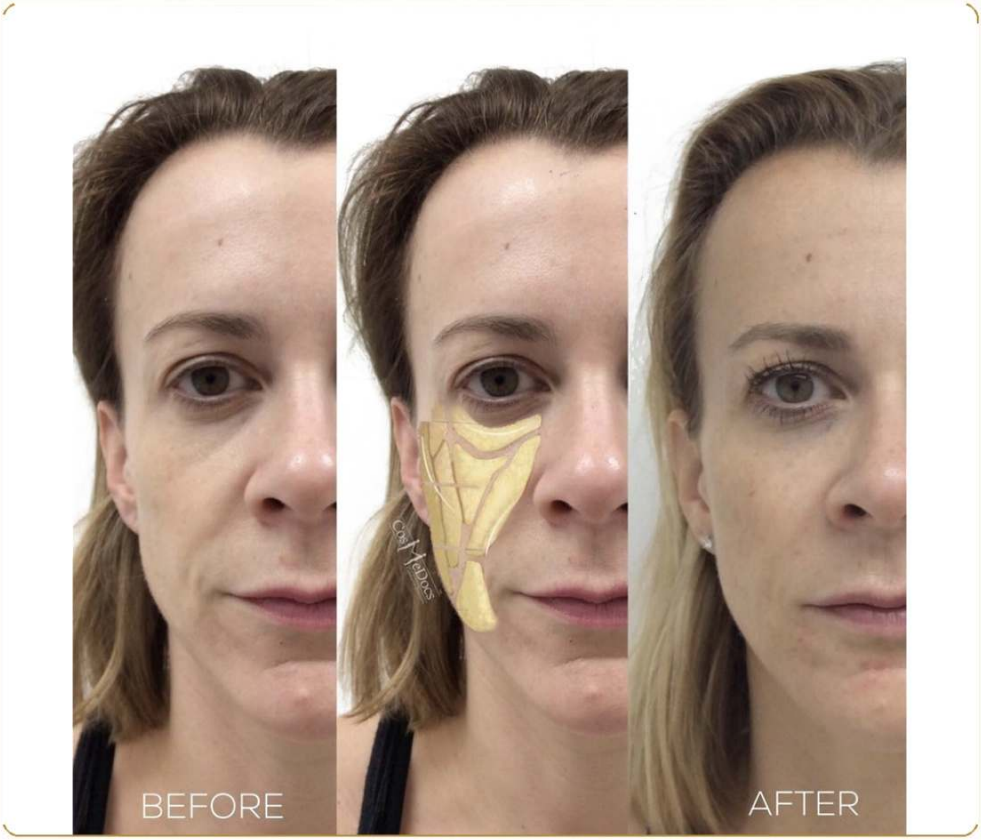
The finger shows the dream.

Our job is to find the least excessive way of moving reality in that direction.

This is also where hyaluronic-acid filler earns a more sensible description than either “miracle” or “poison”. In selected areas, a well-chosen HA gel can behave as a practical substitute for some of the volume or support that has been lost. It is not fat and it does not become fat. It is a manufactured gel with different physical behaviour. But placed in the correct plane and amount, it can replace a missing convexity, soften a hollow, restore

Support the Neighbourhood

Tear trough and upper-cheek volume work as one visual unit.



The aim is not to chase one dark line. Restore the cheek's upper support, soften the lid–cheek junction and use direct trough treatment only where the anatomy earns it. Better transitions usually need less product.

The Tear Trough Is a Transition

A shadow is not always a hole waiting for filler.

The under-eye sits between eyelid, cheek, ligament and light. Treating the trough alone can overfill a narrow space. Sometimes the more elegant correction is support beside it—especially the upper cheek—so the transition reads smoothly again.

projection, improve a transition or rebalance a profile.

That is why good filler is often about proportion rather than “filling”. A small amount in a chin can make a nose look less dominant. Support in the cheek can improve the under-eye without chasing the trough itself. A touch at the mouth corner can alter the resting expression. The clever bit is not the number of millilitres. It is deciding where a millilitre changes the geometry of the face most efficiently.

Filler has also collected a mythology of its own. One myth is that it inevitably migrates around the face. True migration or displacement can occur, particularly in mobile or anatomically constrained areas, but many photographs labelled “migration” are also compatible with product placed in the wrong plane, too much product, repeated topping-up, oedema or simple spread beyond the intended aesthetic boundary. “It migrated” should not become a convenient excuse for poor placement.

Another myth is that filler inevitably makes people look fake. It can. So can a haircut. The problem is not the existence of the tool; it is the judgement used with it. Excess volume, the wrong plane, the wrong product or the wrong aesthetic target can advertise itself from across the room. Conservative work that respects the face should not.

And lip filler does not have to mean big lips. HA always occupies some space, so pretending it is pure hydration with zero volume is marketing. But small amounts can improve hydration, border definition, symmetry and the soft loss of lip substance that occurs with age without producing a pair of inflatable emergency rafts. None of this makes filler trivial. Bruising, swelling, tenderness, infection and delayed inflammatory nodules can occur. Vascular occlusion is rare but potentially serious, and in exceptional cases facial filler has been associated with visual loss. Hyaluronic-acid filler can often be dissolved with hyaluronidase, but having an antidote is not an excuse to inject badly. Prevention, anatomy and restraint still win.

CHAPTER SEVEN

The Woman Who Kept Buying Cheeks

She had excellent cheeks.

This was unfortunate because she had already purchased several more.

The rest of the face had not participated in the investment. Lips full. Cheeks large. Jawline soft. Skin tired. Chin relatively weak. Temples hollowing. The result was not catastrophic; it was simply incoherent.

You could almost see the treatments individually.

This happens because practitioners become treatment-shaped. Learn lips and suddenly everybody needs lips. Learn cheeks and every ageing problem seems to originate somewhere beneath the zygoma. Buy a machine and, by extraordinary coincidence, almost every patient develops the exact condition the machine treats.

If your only tool is a hammer, everybody eventually begins to look suspiciously like a nail.

Faces should be improved as faces.

The aim is not to make the cheek look twenty-eight while the jawline remains fifty-six. It is not to produce a smooth forehead on a face whose skin, posture, hair and lower-face structure are all telling another story.

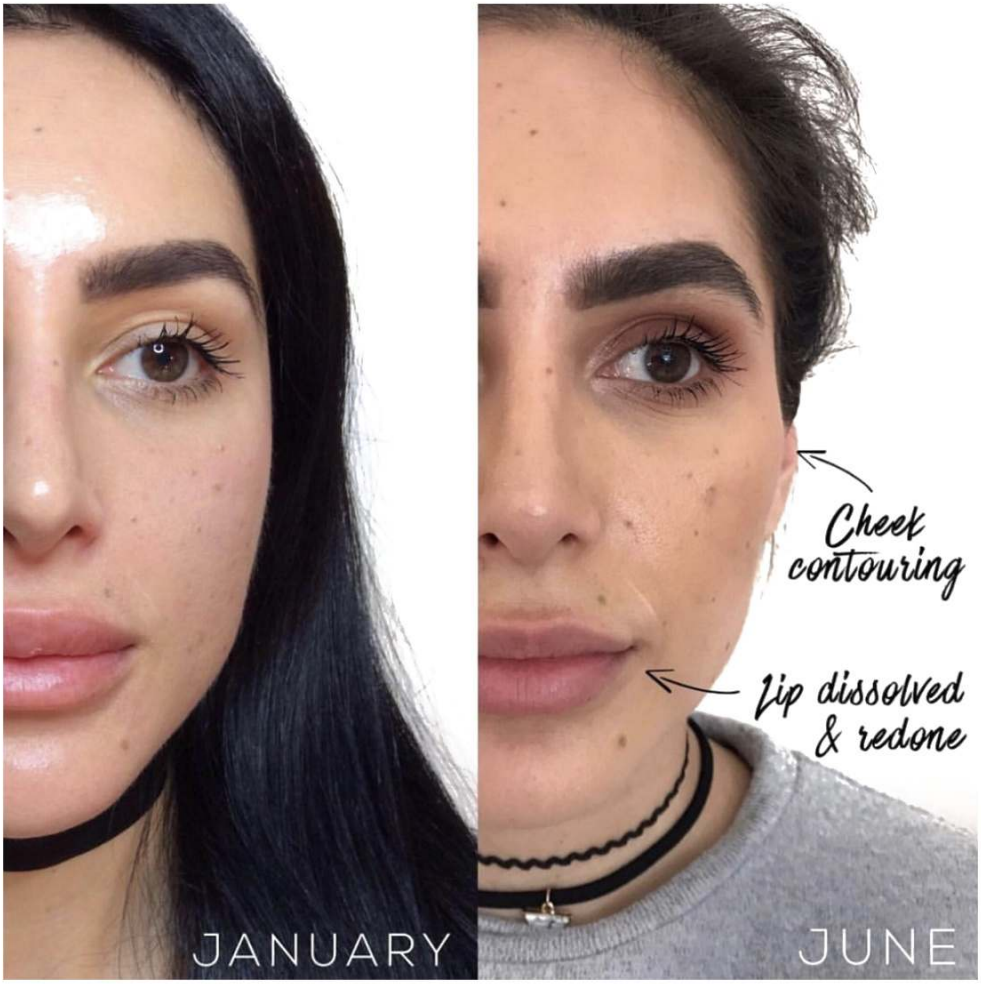
Harmony is not the same as symmetry and it is definitely not the same as maximising every feature.

Sometimes the best filler plan is less filler in more intelligent places. Sometimes it is dissolving old filler. Sometimes it is leaving a feature alone and treating something nobody had previously tried because the practitioner before you only sold lips and cheeks. And sometimes it is doing nothing.

That last technique produces almost no social-media content but has excellent complication rates.

Correct Before You Add

Cheek contouring - and knowing when old filler should come out.



CHEEKS CONTOURED. OLD LIP FILLER DISSOLVED. THE LIP REBUILT WITH RESTRAINT.

Sometimes the best filler appointment begins by removing filler.

ARTICLE

Lift and Volume Together

Why neither works properly alone, and why replacing lost volume completely is neither possible nor desirable.

Once you accept the apple, the plan follows logically. If tissue has deflated, it needs volume. If tissue has descended, it needs support. Most faces need both, and the order matters.

Support without volume can look tight and drawn — a small apple in a well-fitted skin. Volume without support fills a face that is still falling, and the filler comes along for the ride, usually in the direction you least wanted. The two are not competing options. They are two halves of the same correction.

THE LIMIT NOBODY ADVERTISES

Here is the part patients are rarely told: you cannot fully replace naturally lost facial volume with filler. Not because the products are inadequate, but because the loss is distributed through multiple compartments, at different depths, over different planes, and it is accompanied by bone that has changed shape underneath.

Attempting to replace all of it, millilitre for millilitre, is precisely how faces stop looking like themselves. The tissue is loaded beyond what it was designed to carry, the light falls in the wrong places, and the result

reads as treated from across a room. Everybody has seen it. Nobody books it deliberately.

WHAT WE AIM FOR INSTEAD

Enough structural volume in the right planes to restore support and transitions, combined with lift where descent is the real finding, and skin quality work underneath all of it. Partial restoration, correctly placed, beats full restoration badly distributed every time.

The goal is not a face returned to a photograph. It is a face that is recognisably yours, better supported than it was, doing nothing that announces itself.

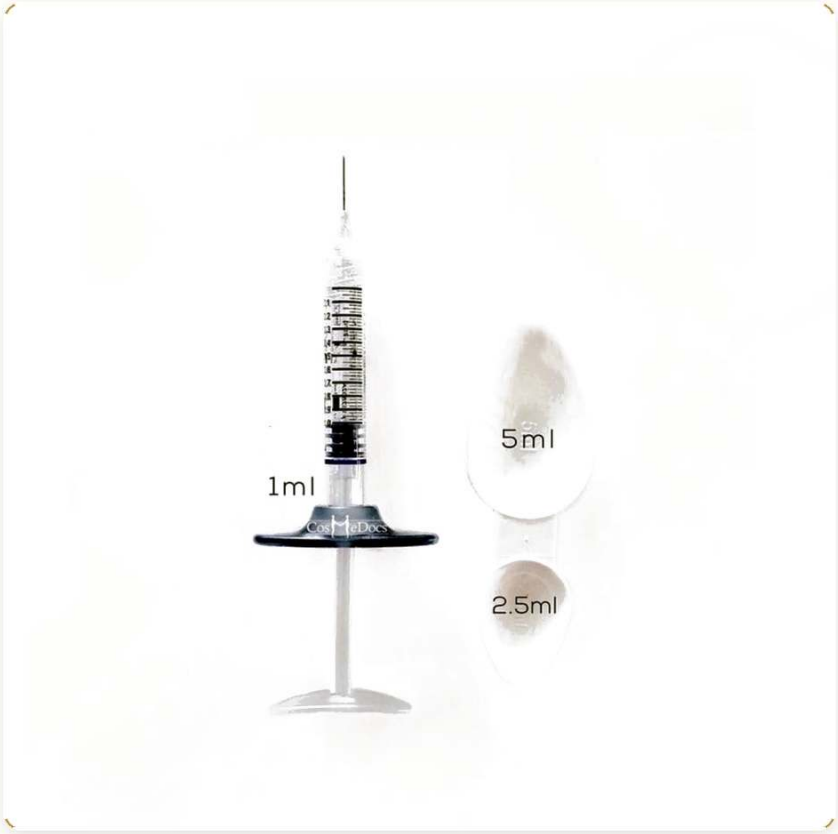
PART FOUR

Materials: What We Put In

On hyaluronic acid, patience, and the treatments I decline to offer.

A millilitre is smaller than it sounds.

Scale matters before material does.



1 mL = one fifth of a 5 mL teaspoon

The question is not how much filler can be placed. It is how little is needed to restore proportion.

Volumes shown for scale; treatment plans remain individual.

CHAPTER EIGHT

Boring Is the Point

On hyaluronic acid, patience, and a simple test I apply to every new material: would I have it in my own face?

Hyaluronic acid has been the mainstay of dermal filler for over two decades, and I am aware that saying so out loud is dull. Nobody has ever been excited by a substance their own body already makes.

It remains the gold standard anyway, and for reasons that have nothing to do with marketing.

WHY IT EARNS ITS PLACE

It is a material the body recognises. It is water-loving, which is why it integrates rather than sitting as a foreign lump. Its behaviour can be engineered — firmer for structural support over bone, softer and more mobile for a lip or a fine line — so the same chemistry can do quite different jobs when the right product is chosen for the right plane.

And crucially, it can be removed. There is an enzyme that dissolves it. If a result is wrong, if a patient changes her mind, if anatomy behaves unexpectedly, there is a way back. I will return to that in the article that follows, because I consider it the single most underrated feature in aesthetic medicine.

Filler Has a Sense of Humour

The internet occasionally does too.

If the treatment announces itself before the person does, the joke may be on the treatment plan.

People assume gold standard means unchanged. It does not. The formulations improve every year — better cross-linking, better tissue integration, more predictable behaviour under movement, longer duration without added stiffness. The improvements are incremental and quiet, which is exactly what you want from something being placed in a face.

THE MATERIALS I DECLINE

There is a steady supply of alternatives promising longer duration. Poly-L-lactic acid. Other semi-permanent and biostimulatory materials. Occasionally something frankly permanent, which is always presented as an advantage.

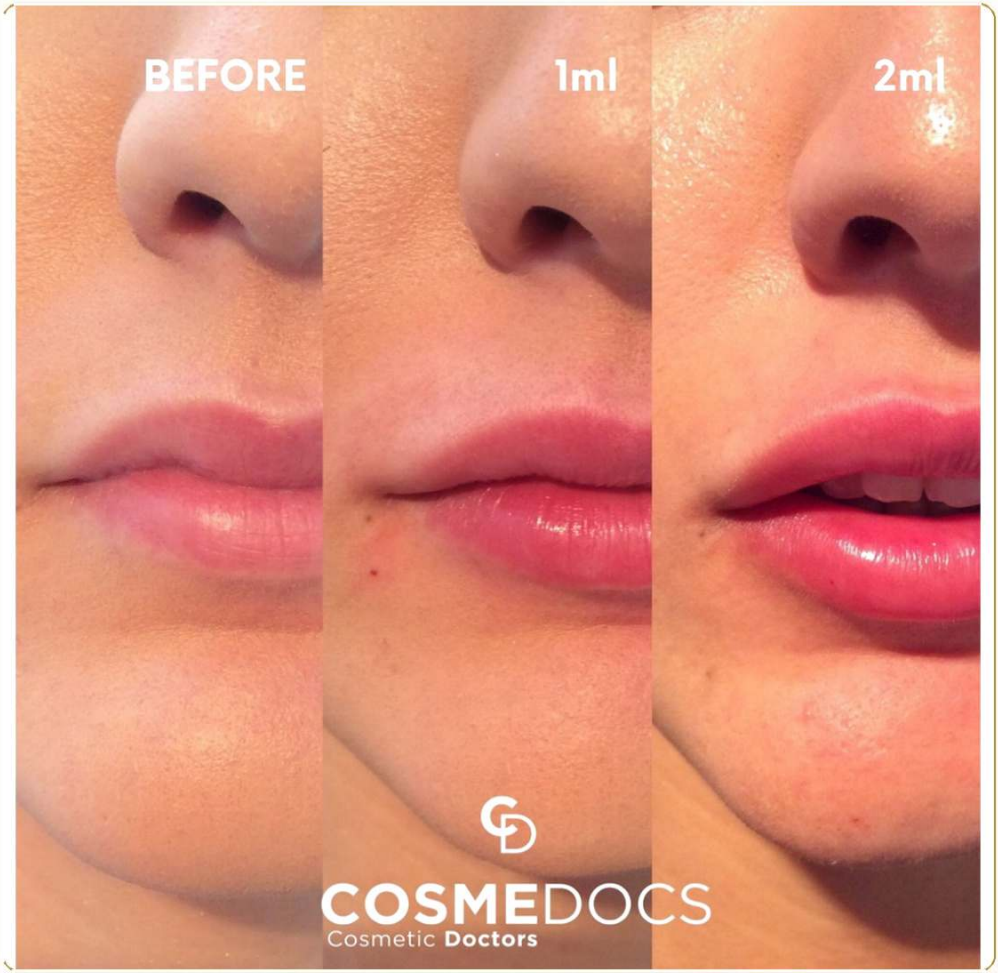
I do not offer these on the face. Not because they are unlawful, and not because nobody gets a good result from them, but because the arithmetic of risk is different. A longer-lasting material means a longer-lasting problem. If a semi-permanent product nodulates, migrates, sits too superficially or simply looks wrong in five years when the face beneath it has changed, the options narrow considerably. There is no enzyme. There is sometimes surgery.

Faces are not static targets. A material that suits your anatomy today has to still suit anatomy you will not have for another decade — because bone will have retreated a little further, fat will have redistributed, and the product will still be exactly where it was put.

I apply one test to every new material: would I have it in my own face? Until the answer is yes, I am not going to offer it to somebody who trusts me. That is the entire policy, and it has aged rather well.

One Millilitre Is Small

It is one-fifth of a teaspoon. Placement still matters.



One or two millilitres can create a visible change in the right anatomy. The question is never only how much—it is where, why and whether the face needs it.

This occasionally costs us business. A patient who wants three years from one appointment will find somebody willing to provide it. I understand the appeal — fewer visits, better value on paper. But the value only holds if nothing needs changing, and in twenty years I have not met many faces where nothing needed changing.

So we stay boring. Reversible, predictable, adjustable, unglamorous. Every year the material gets slightly better and the philosophy stays the same.

FIELD NOTE

Filler myths: what hyaluronic acid can and cannot do

MYTH	REALITY
"Filler is just for making things bigger."	HA filler can replace selected lost volume, restore support, smooth transitions and improve proportion. It is not biologically the same as fat.
"Filler always migrates."	True migration can occur, but apparent "migration" may also reflect poor placement, overfilling, repeated treatment, oedema or spread.
"Filler always looks fake."	It looks fake when volume, plane, product or proportions are wrong — or when an exaggerated look is deliberately chosen.
"Lip filler means big lips."	Small amounts can restore hydration, border, symmetry and age-related substance. Any HA gel still adds some volume.
"Because HA dissolves, it is low-risk."	Most effects are temporary, but vascular occlusion and other complications can be serious. Dissolving is rescue, not permission to be casual.

Things I Learnt About Filler

Apparently, from Instagram.

IT ALWAYS MIGRATES

Migration can occur. So can wrong plane, excess, repeated top-ups, oedema and spread.

IT ALWAYS LOOKS FAKE

The tool is not the aesthetic. Product, plane, amount and judgement decide what shows.

LIP FILLER IS JUST HYDRATION

HA occupies space. Small amounts can be subtle; 'zero volume' is still marketing.

ARTICLE

Reversibility Is a Safety Feature

Duration is a marketing figure. Being able to undo the treatment is a clinical one.

Patients compare fillers by how long they last. Clinicians, if they are honest, compare them by what happens when something goes wrong.

Hyaluronic acid can be dissolved with hyaluronidase, an enzyme that breaks it down within hours. That single fact underwrites almost everything else we do with it.

THREE SITUATIONS WHERE IT MATTERS

First, the emergency. A filler placed near a blood vessel can, rarely, compromise its supply. This is the complication every responsible clinic prepares for, and the response depends on being able to dissolve the material immediately. Hyaluronidase is kept on site for that reason and has never been something we would work without.

Second, the correction. Filler placed too superficially, unevenly, or in a plane that flatters the patient less than expected. With a reversible material this is an inconvenience. With a semi-permanent one it can be a five-year problem.

Third, the change of mind — and the change of face. Some patients simply decide, later, that they would rather have less. Others accumulate filler over a decade in a face that has been quietly reshaping itself underneath, and the honest treatment is not more, but removal and a fresh start.

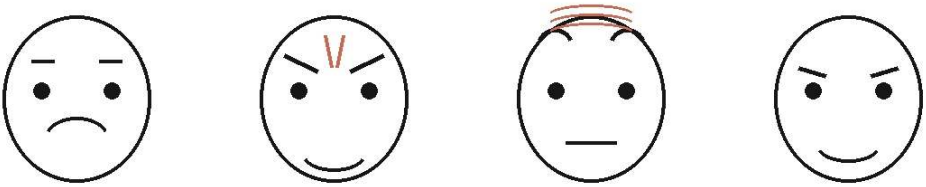
Choosing a material you can remove is not timidity. It is the recognition that you will occasionally be wrong, that anatomy varies, and that patients are entitled to change their minds.

So when a product is presented to me on the strength of lasting three years, I hear the sentence differently. I hear: this will be in the patient's face for three years, whatever happens, whatever changes, whether or not either of us still likes it.

PART FIVE

Lines at Rest, Lines in

EXPRESSION -> REPETITION -> LINE AT REST



AT REST | READING FROWN | SCREEN BROWS | CONCENTRATION

MOVEMENT IS NORMAL.

The unnecessary part is leaving the same expression switched on all day.

Treat the habit and the cause - not simply every line you can see.

CHAPTER NINE

Unnecessary Expressions

We evolved faces to communicate long before we had email, emojis or the passive-aggressive full stop.

A raised eyebrow, a smile, a grimace, a frown, a squint - the face is an extraordinary messaging system. There is an appealing evolutionary idea that our relatively hairless faces make these signals easier to see. I like the story, although the biology is more complicated than one neat explanation. Human facial hairlessness almost certainly had several pressures behind it.

The important bit is simpler: the face was designed to move. The problem is that some of us keep certain expressions running long after they have stopped communicating anything useful. I call these unnecessary expressions.

Some people frown when they read. Frown when they drive.

Frown when they concentrate. Frown while watching television. Occasionally they appear to frown in their sleep, presumably because the subconscious has found something objectionable. Then there are screens.

A desktop can make somebody raise their eyebrows for hours. A laptop changes head position and concentration patterns. A phone puts the neck down and the eyes into another habitual relationship. None of this means mobile phones have invented a new dermatological disease called screen

lines. That would be too convenient. It means modern life gives us thousands of opportunities to repeat the same expressions without noticing. Outside, the problem changes. Bright sun produces squinting. Driving into low light for years gives the orbicularis and frown complex plenty of exercise. Put that on top of photoageing and a young face can acquire lines surprisingly early.

Ask somebody to relax their forehead. They do. Two seconds later the eyebrows are back up.

“Relax.”

Down.

Up again.

I have not injected anything and we have already learned something.

Some movement is expression. Some is compensation. Some is habit. Some is simply unnecessary mileage.

The frown complex is particularly interesting because patients associate it not only with looking angry but with tension and headache. We should be precise here: frowning does not universally cause migraine. Migraine is a neurological disorder, not an eyebrow personality problem. But botulinum toxin has a separate established medical role in chronic migraine, using multiple injection sites across the head and neck. Its therapeutic effect is not merely “relax the frown”; pain-signalling biology is involved as well.

That is an important lesson because the same molecule can have an aesthetic job and a medical job without those being the same job.

In ordinary aesthetic treatment, the goal should not be to freeze a face. A completely immobile forehead is not automatically youthful. It is immobile.

I am trying to negotiate with the muscles.

Keep useful expression. Reduce repetitive forces that are doing unnecessary work. Preserve compensation where the patient needs it. If somebody is raising the brows to compensate for heavy lids, aggressively removing frontalis activity because there are horizontal lines can make the patient beautifully smooth and wonderfully furious.

The wrinkle is evidence. It is not always the diagnosis.

FIELD NOTE

Movement: what a line is trying to tell you

WHAT YOU NOTICE	POSSIBLE DRIVER	WHY IT MATTERS
Line only during expression	Dynamic muscular folding	Movement treatment may be enough
Line remains at rest	Movement plus established skin change	May need movement control plus skin repair
Constantly raised brows	Frontalis compensation	Reducing it without assessment can worsen heaviness
Square lower face / clenching	Masseter hypertrophy, bone or fat	Toxin only treats the muscular component
Headache / migraine concern	Neurological or musculoskeletal condition	Requires medical diagnosis; migraine protocols are not cosmetic frown treatment

Movement is normal. Repetition plus changing skin can make a temporary crease become visible at rest.

ARTICLE

Dynamic and Static: The Stretch Test

A line that vanishes when the face stops moving and a line that stays are two different problems with two different answers.

There is a test that takes five seconds and decides most of the treatment plan around a wrinkle.

Sit still. Let the face go completely neutral. Look at the line.

IF THE LINE DISAPPEARS AT REST

It is dynamic. It exists because a muscle is pulling, repeatedly, in the same direction, and the skin folds where it always folds. The line is a symptom; the repeated force is the cause. Reduce the unnecessary part of that force and the skin stops being folded a few thousand times a week — and it usually improves on its own, because it was never structurally damaged in the first place.

This is also the stage at which small intervention does the most work. Prevention is an unpopular word because it sells nothing dramatic, but a line that has not yet set is far cheaper to manage than one that has.

IF THE LINE REMAINS AT REST

It is static. The skin itself has been remodelled along the fold. Reducing the movement will stop it deepening, but it will not remove what is already there. Static lines need the skin treated as well — resurfacing, collagen stimulation, sometimes a small amount of the right material placed in the line itself, sometimes simply better skin quality over months.

IF GENTLY STRETCHING THE SKIN ERASES IT

Then the deficit is in the skin and the support beneath it, not in the muscle at all. This is the finding people most often misread, and the one that leads to years of treating movement in a face whose problem was never movement.

Keep useful expression. Reduce repetitive forces doing unnecessary work. Treat what has already set as a skin problem rather than a movement problem. Most bad results come from applying one of these three answers to the wrong question.

PART SIX

Judgement, Money and Restraint

The part of aesthetic medicine that has nothing to do with needles.

CHAPTER TEN

There Isn't a Best Treatment

Every patient eventually asks the same question.

“What is the best thing for collagen?”

This is like asking, “What is the best vehicle?”

Going to Tesco? Crossing the Sahara? Invading Poland?

Different trip. Different vehicle.

For skin quality I think in layers rather than favourites. At the base sits the boring, consistent work: appropriate cleansing, photoprotection, retinoid-type therapy when suitable, antioxidant support and sensible barrier care.

Above that come controlled interventions. Peels can help selected surface and pigment concerns. Microneedling creates controlled injury and repair. PRP uses a patient’s own platelets and signalling environment as an adjunct in selected cases.

Then come injectable skin-quality treatments. Hyaluronic-acid- based remodelling treatments such as Profhilo may suit a patient with decent structure but crepey, dehydrated or less elastic skin. Amino-acid and HA formulations such as Sunekos-type treatments occupy a related but different category.

Polynucleotides are used for gradual tissue-quality support, often around thin or crepey areas such as the periorbital region. Then there are exosome-based approaches, biologically interesting and increasingly fashionable, but still a category where products, evidence and regulation are less uniform than the marketing sometimes implies.

The top costs more.

That does not mean the top is better.

It means the top should usually be more selective.

A patient with pigmentation does not automatically need a regenerative injectable. A patient with acne scars may need scar- specific treatment. A patient with a short chin does not need an optimistic polynucleotide to grow a mandible by lunchtime. There is no best treatment.

There is a best next treatment for this problem, in this patient, at this budget, at this stage.

That distinction could save people an extraordinary amount of money.

MORNING

- Wash
- Antioxidant
- Sunscreen

EVENING

- Wash
- Retinoid programme
- (when suitable)

Four jobs, not twelve bottles. Add extra products only when a specific skin problem earns them.

CHAPTER ELEVEN

Tell Me What You Want to Spend

Nobody likes discussing money in a medical consultation.

Patients suspect the doctor is trying to discover the maximum available balance on the credit card. Doctors worry that asking makes the whole thing sound like selling a used Mercedes.

But in elective aesthetics, budget is useful.

Very useful.

Suppose I identify five things that could genuinely improve. That does not mean you need five treatments.

Tell me you have £500.

Fine. My job becomes: what can I do for £500 that creates the largest useful change?

Tell me £1,000. Now I have more options.

Tell me £5,000 and I may still tell you to spend £800.

That is what trust is supposed to buy.

After seventeen or eighteen years in practice, the most valuable thing you accumulate is not stock. It is the ability to say no without wondering whether the rent depends on the answer.

No more filler.

No, that device is not the best use of your money yet.

No, you do not need a fashionable treatment because somebody online has discovered a new facial ratio.

And occasionally: no, go home.

Aesthetic medicine is elective. Nobody dies because their cheek projection remains two millimetres suboptimal until Thursday. That should make honesty easier, not harder.

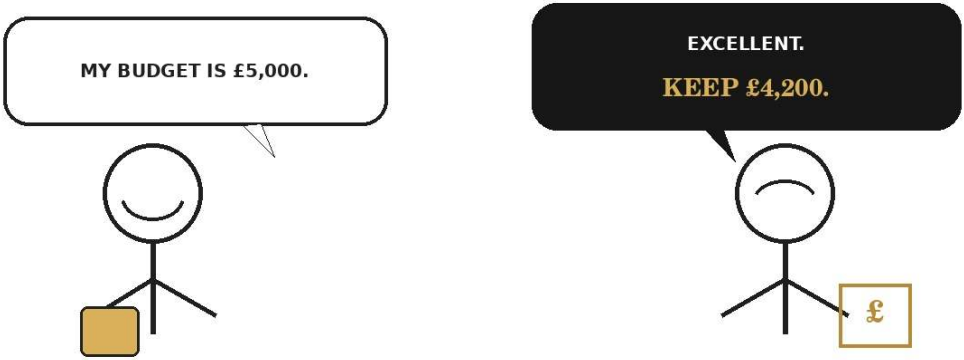
So tell me the budget. It is a ceiling, not a target.

If you give me £500, my ambition is to prioritise it so intelligently that the visible improvement feels as though you spent more. If you give me £1,000, I want the plan to outperform the random £2,000 treatment menu you might otherwise have collected over six months.

That is not a literal promise to double money. I have not found a way to do that, or this would be a very different book.

It is a promise about judgement.

The expensive part of aesthetic medicine should be judgement, not millilitres.



A BUDGET IS A CEILING, NOT A TARGET.

Beautification, Not Transformation

Seven examples. Different tools. The same rule: keep the person.

01 FULL-FACE GENTLE MAKEOVER · HYALURONIC ACID

02 CALF REDUCTION

03 NON-SURGICAL NOSE JOB · 10 MINUTES

Small Changes. Clear Intent.

Treat the feature that matters. Leave the rest of the face alone.

04 JAWLINE SLIMMING · BOTULINUM TOXIN

05 CHIN ENHANCEMENT

06 CHIN + CHEEK ENHANCEMENT

07 #BEAUTIFICATION

THE BEST RESULT IS NOT A NEW FACE.

It is your face, making more sense.

Clinical photography supplied by Cosmedocs. Individual results vary.

CHAPTER TWELVE

The Face at Six Inches

“Look at this pore.”

I looked.

It was a pore.

There were several million accomplices nearby.

She had the mirror approximately eight inches from her face. Nobody else sees you like this. Not friends. Not colleagues. Not even somebody sharing your bed unless the relationship has taken a very strange dermatological turn.

So I use distance.

At twenty feet I see the person: posture, hair, movement, silhouette, body composition, style, energy, the way light reflects from skin.

You can often estimate age before you see a wrinkle because age lives everywhere. Gait changes. Posture changes. Hair changes. Body composition changes. Speed changes. Aesthetics is not the first layer of self-care; it is the next layer after the basics. At five feet I see the social face: expression, overall skin quality, cheeks, jawline, eyes, balance.

At two feet I see more texture, pigment and treatment detail. At one foot I can find faults on anyone.

The human face was not manufactured by Apple.

This matters because people increasingly design themselves for inspection distances that life rarely uses. High-definition front- facing cameras, magnifying mirrors, endless selfies - they all encourage the brain to stop seeing the person and start auditing the surface.

A face should work in a room.

It should work when you walk into a restaurant, stand at a bar, sit across a table, meet somebody at work, or wake up beside someone who is hopefully not carrying a ring light.

That is why I occasionally tell a patient to spend the money somewhere else first.

Hair. Teeth. Weight. Sleep. Posture. Clothes. Fitness. Grooming. A beautiful jawline attached to somebody who has otherwise given up still looks like somebody who has otherwise given up. Aesthetics should complete the picture, not distract from it.

20 FEET	Silhouette, posture, hair, presence
5 FEET	The face as a whole
2 FEET	Skin, expression, proportion

AT SIX INCHES, EVERYBODY NEEDS WORK.

Nobody else sees you like this - unless the relationship has become strangely dermatological.

CHAPTER THIRTEEN

The Handsome Problem

Men are where the textbook gets particularly unreliable.

Patients often imagine male beautification means improving each feature individually: straighten the nose, sharpen the jaw, strengthen the chin, smooth the skin, remove every irregularity. Do that carelessly and you can remove the man from the face. After enough years treating faces, you begin recognising something that is difficult to reduce to one measurement:

attractiveness is not a feature-by-feature score. It is the way features cooperate with a persona.

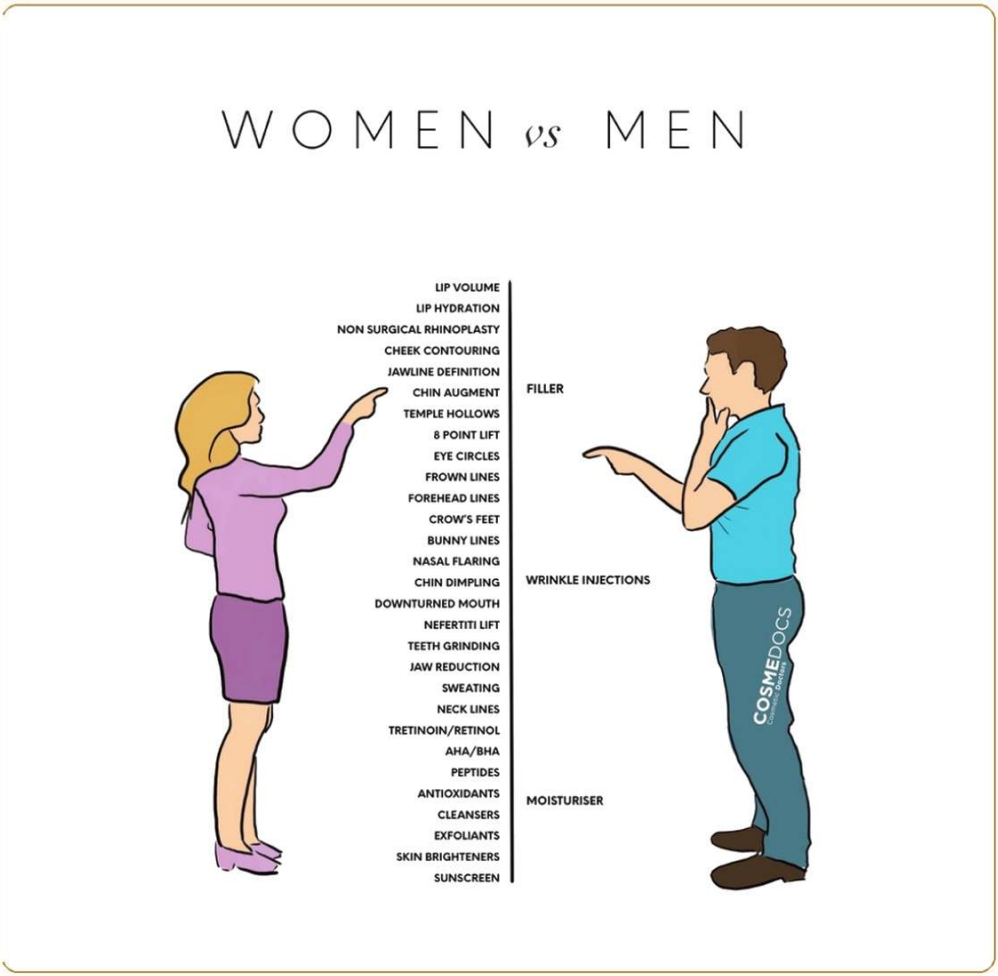
A rugged nose can be attractive. In fact, making it smaller or smoother can reduce the face if the rest of the man is strong, angular and masculine. Sometimes I will leave the nose alone and create more agreement elsewhere - chin, jaw, cheek, hair, skin quality - so the nose stops looking like the problem and starts looking like character.

The same is true of asymmetry. Perfect symmetry is not the aim. Faces are alive because they are not CAD drawings.

Some patients come to aesthetics because they want to feel more attractive in dating. People sometimes use the phrase “sexual marketplace value”, which sounds as though romance has been outsourced to an investment bank. I do not love the phrase, but I understand the concern underneath it.

Men Read a Different Menu

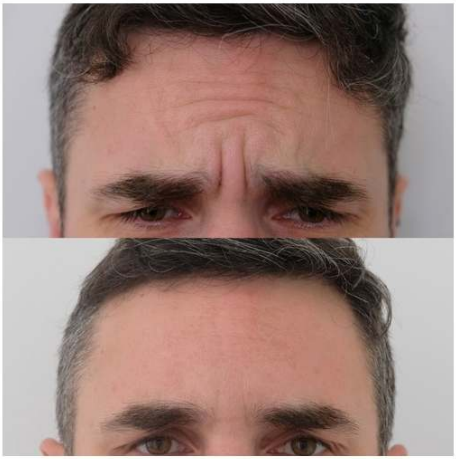
The joke is exaggerated. The design problem is real.



Masculine treatment is not simply less treatment. It is different balance: stronger structure, controlled softness and no accidental feminisation unless that is the patient's aim.

Four Ways to Treat a Man

Reduce what distracts. Restore what is missing. Keep the man in the face.



01 FROWN REDUCTION

02 MID-FACE VOLUME + SKIN REJUVENATION

03 NOSE-TIP LIFTING

04 GUMMY-SMILE REDUCTION

THE AIM IS NOT A 'PERFECT' MALE FACE.

It is a more coherent version of the one already there.

Clinical photography supplied by Cosmedocs. Individual results vary.

They want to move up a notch in how they are perceived. They want more choice. They want to feel that the kind of person who used to overlook them might look twice. Or perhaps they do not want a new partner at all; they simply want the validation of knowing they could.

That is real human motivation. It should be acknowledged without pretending attraction can be calculated like a mortgage rate.

My job is not to maximise a universal attractiveness score. There is no single ideal male face. Attraction contains sex, age, ethnicity, grooming, voice, body, posture, personality and context. The face is only one part of the signal.

But within the face, I can often increase coherence. A weak chin may make a large nose dominate. Strengthen the lower face and the same nose suddenly looks intentional. A narrow jaw can make the midface feel top-heavy. Improve the lower third and the entire face becomes more credible. Rougher skin may suit a rugged man better than making him look artificially polished; healthier skin does not mean porcelain skin.

The creative part of aesthetics is not inventing a new person. It is deciding which characteristics deserve reinforcement. Sometimes prettiness is the wrong objective.

Attraction can be handsome, elegant, rugged, soft, glamorous, severe, cute, striking or simply difficult to stop looking at. The most attractive feature may be the one I refuse to fix.

Restoration puts back what changed. Beautification changes a proportion that may always have been there.

Thank You for the New Face

All non-surgical. We will not tell the secret.

BEFORE **AFTER**

THIS IS ALL NON-SURGICAL.

But we will not tell the secret.

Photographs supplied by Cosmedocs. Lighting and styling differ. Individual results vary.

CHAPTER FOURTEEN

Thank You for the New Face

I spend a great deal of time telling doctors not to change faces too much.

Naturally, occasionally I change one quite a lot.

There is a fashionable belief that subtle treatment must mean small treatment.

It does not.

Subtle means the treatment does not announce itself.

Sometimes that requires almost nothing. Sometimes it requires considerable structural work.

A markedly retruded chin, weak lower face, under-supported midface or dominant nose can affect how every other feature is perceived. Change one important structural relationship and several untouched features suddenly improve.

The nose appears smaller because the chin now competes with it. The lips look better because the lower third has balance. The jaw looks stronger. The profile becomes more coherent.

That is when aesthetic medicine becomes creative.

Not creative in the sense of making things up while holding a needle. Creative in the same sense as architecture: rules, structure, engineering constraints, then judgement.

One patient required more structural change than I would usually describe as a tweak. She was delighted.

Some time later she travelled through an airport and the automated passport scanner failed to recognise her.

She tagged me in the message.

“Thank you for the new face.”

Not exactly the outcome measure they teach at medical school. I could already imagine the trial paper: primary endpoint, failure of border-control facial-recognition software.

But the story made an interesting point.

We had changed quite a lot, yet the face did not look strange. The features simply agreed with one another more convincingly. The magnitude of treatment and the obviousness of treatment are not the same thing.

A millilitre in the wrong place can look ridiculous. Several carefully planned changes across the right structural relationships can disappear into the face.

Sometimes you do very little and achieve a lot.

Sometimes you do quite a lot and it looks like you did nothing. And occasionally you do enough that the airport becomes suspicious.

CHAPTER FIFTEEN

The Face You Cannot Put Back

She had once been a supermodel.

Not "model" in the modern sense of owning a ring light and placing the word in an Instagram biography. A real one.

Professionally photographed. A face other people had once been paid to light correctly.

That creates an unusual problem when time moves on, because most of us compare ourselves with memory. She had archives. Old campaigns. Editorial photographs. Images taken when the skin, fat, muscle and underlying skeleton were living in a different arrangement.

By the time she came to me, she had also been treated in pieces over the years. Botox here. A little filler there. Lips at one clinic, cheek at another, perhaps something new because a treatment had launched and everybody suddenly needed it.

Nothing catastrophic. Just no single hand on the steering wheel. And time had not changed one thing. It had changed everything quietly.

The skin was different. Pigment and texture had accumulated. The dermis had changed. Repeated movement had left lines. Soft- tissue compartments no longer sat in quite the same relationship. Temples, under-eyes, cheeks, lips, chin and jawline were now negotiating with a face that had been alive

for decades longer. Bone itself remodels with age, particularly around the orbit, maxilla and mandible, so even the framework onto which we might be tempted to “put the old volume back” is not exactly the framework that existed in youth.

This is where simplistic restoration fails.

If I took an old photograph and tried to recreate her twenty-five- year-old cheeks on the face she has now, I would not necessarily make her younger. I might simply make her older face larger. The job changes.

I am no longer asking, “What did she used to have?” I am asking, “What do we have now, and what can be made harmonious with it?”

That is a very different programme.

First, the skin. There is little point rebuilding beautiful architecture and viewing it through tired glass. Improve turnover. Control pigment and inflammation. Support the dermis. Use procedures when they earn their place.

Then movement. Which expressions are still useful? Which muscles are compensating? Which lines belong to the personality and which are simply unnecessary mileage?

Then structure. Where has support genuinely changed? Where would a small amount of volume restore a transition? Where would volume simply make the face heavier? Does the chin need more authority because the jaw has changed? Does the cheek need less than instinct suggests? Does the temple need attention because the rest of the face now looks disconnected from it? And then comes the part that is difficult to teach from a syringe diagram: composition.

This is where an artistic eye matters.

Not because aesthetic medicine becomes freehand sculpture. Anatomy still wins. Safety still wins. Vessels do not become more cooperative because the doctor considers himself creative. But once the anatomy is understood, judgement begins.

Some hollows should remain because they give character. Some noses should remain strong because the face becomes more interesting when the rest of the structure supports them. Some lips should be left alone. Some jawlines need more work than the cheeks. Sometimes restoring asymmetry too perfectly makes the face less attractive rather than more.

The aim is not to rebuild the past. It is to reconstruct harmony from the anatomy that remains.

That is why an older patient requires a different programme from a twenty-three-year-old protecting her skin or a thirty-two-year- old replacing the first hints of volume loss. Prevention becomes maintenance. Maintenance becomes restoration. Eventually restoration becomes reconstruction.

And reconstruction is selective.

We improved her skin. We softened selected muscular forces. We restored support where it mattered and deliberately did not fill every hollow that appeared on a photograph. The later pictures did not look like the old model photographs.

Good. They were not supposed to.

They looked like the woman standing in front of me now, only more coherent.

That may be the most important lesson in the book.

Aesthetic medicine is not a photocopier for youth. At its best, it is an editor.

It removes what distracts, restores what is missing, protects what is still working and knows when the most beautiful feature on the face is the one it leaves alone.

You cannot make the old face come back. But you can sometimes make the present face make sense again.

The Face Behind the Story

The photographs that belong to this chapter.

ONE FACE. YEARS OF SMALL, DELIBERATE DECISIONS.

01 THEN

02 BUILD

The face was never replaced. The plan simply learned when to stop.

Refine. Then Maintain.

Later years, still recognisably the same face.

03 REFINE

04 MAINTAIN

The aim was not to put back the past. It was to keep the present face coherent.

Photographs shown exactly as supplied — no facial cropping or retouching.

EPILOGUE

The Mirror Moves Back

Months later, the model came back.

Her skin was clearer. Movement was calmer where it needed to be. Small areas of support had been restored. The face looked more rested without becoming somebody else.

She picked up the mirror.

I watched.

The first time I had met her she held it close. Most people do. They zoom into themselves until the person disappears and all that remains is a collection of concerns.

This time she held it farther away.

Not deliberately. She simply did.

She looked at the whole face.

“I look like myself.”

That sentence stayed with me.

Because perhaps that is what many patients were asking for all along.

Not youth.

Not perfection.

Recognition.

The person in the mirror had caught up, just slightly, with the person in her head.

Aesthetic intelligence is not knowing every treatment. It is not owning the most expensive skincare shelf. It is knowing what matters.

Skin. Movement. Shape. Support. Proportion. The rest of the person carrying the face.

And then having enough judgement to know when to intervene - and enough confidence not to.

The best aesthetic treatment is sometimes a syringe.

Sometimes a skin programme.

Sometimes a haircut.

Sometimes losing weight, improving fitness and standing up properly.

And occasionally, wonderfully, nothing at all.

A NOTE FROM DR HAQ

The technical act is the easy part

I trained in surgery before aesthetic medicine became my second career. That background taught me something that has become more useful with every year I practise: the technical act is usually the easy part.

The difficult part is deciding whether anything should be done at all.

This book is not an argument for more treatment. It is an argument for better diagnosis, better sequencing and a face that still belongs to the person who walked in with it.

If you remember only one sentence, remember this:

The face should determine the treatment.
The treatment should never determine the face.

Cosmedocs — Harley Street, London · Clinic edition, 2026

AESTHETIC INTELLIGENCE

Mostly natural.
Sometimes bold.
Never apologetic.
Always yours.

A patient's guide to reading the face before treating it.

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DR AHMED HAQ