apogēe

APOGÉE CLINIC · DR SHIVA AESTHETICS

THE AESTHETIC PASSPORT

Your face. Your history. Your future.

COMPREHENSIVE FACIAL & NECK ULTRASOUND ASSESSMENT

CASE

Anonymised Sample Report — Bilateral Cheek Soft-Tissue Assessment

PATIENT / IDENTIFIER	EXAMINATION DATE	REPORT DATE	REPORT VERSION
Anonymised sample	Withheld (anonymised)	Withheld (anonymised)	Sample edition 1.0

Dr Shiva Faramarzi, MD
Aesthetic Physician · Examining Physician

Dr Abdul Rahman Alvi
Consultant Vascular & Interventional Radiologist

WELCOME

About your Aesthetic Passport

The Aesthetic Passport is a clinical imaging record you can keep and share with future treating doctors.

It documents your current facial anatomy as seen on high-frequency ultrasound, any identifiable previous injectable material, relevant soft-tissue findings, the interpretation of those images, and a personalised plan for future treatment.

Its purpose is not to reconstruct a complete history of every treatment you have had. It records **what can be assessed today, what is known, what remains uncertain** and how future treatment should be approached.

ABOUT THIS SAMPLE

This anonymised sample concerns **bilateral cheek soft-tissue abnormalities** only. It does not document a complete examination of every facial and cervical region, and no other region should be assumed normal on the basis of this report. Clinical content is reproduced from the original anonymised report; the layout has been redesigned.

HOW STATEMENTS ARE DISTINGUISHED

HISTORY	As reported by the patient
REAL-TIME	Observed by the examining physician during live scanning
STORED IMAGE	Visible on the recorded clips
INTERPRETATION	Imaging differential; not a diagnosis
RECOMMENDATION	Suggested next steps for the clinical team

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MEET YOUR MEDICAL TEAM

Two physicians, two distinct roles



Dr Shiva Faramarzi and Dr Abdul Rahman Alvi at Apogée Clinic, Address Beach Resort, JBR, Dubai.

Dr Shiva Faramarzi, MD

AESTHETIC PHYSICIAN

Clinical examination, high-frequency ultrasound acquisition, anatomical mapping, clinical correlation and personalised aesthetic treatment planning.

Dr Abdul Rahman Alvi, MRCS, FRCR, CCT (UK)

CONSULTANT VASCULAR & INTERVENTIONAL RADIOLOGIST

Independent radiological review of the acquired ultrasound images, interpretation of imaging findings and recommendations for further investigation where indicated.

Complementary, not interchangeable. The examining physician performs the clinical consultation and acquires the ultrasound images in real time. The consultant radiologist reviews the stored images independently and does not necessarily attend the examination. Each Aesthetic Passport states whether, and when, consultant radiologist review has taken place. For this anonymised sample, consultant radiologist review and sign-off are not documented (see Section 15).

YOUR ASSESSMENT EXPERIENCE

From consultation to clinical record

01 **Clinical consultation**
Discussion of your concerns and review of any available treatment history.

02 **High-frequency ultrasound**
Examination with a Clarius high-frequency linear transducer.

03 **Colour Doppler**
Assessment of blood flow where clinically indicated.

04 **Systematic mapping**
Documentation of relevant findings by region, depth and appearance.

05 **Consultant radiologist review**
Independent review of the stored images.

06 **Your illustrated report**
Preparation of this Passport with personalised clinical recommendations.



Collaborative ultrasound assessment at Apogée Clinic, with Dr Abdul Rahman Alvi and Dr Shiva Faramarzi.

YOUR PREVIOUS RECORDS

Previous medical and treatment records are helpful but not mandatory. Please bring whatever you have — product names, dates and clinic details all help to interpret the images.

WHAT ULTRASOUND CAN AND CANNOT SHOW

Ultrasound may identify or characterise some previous injectable deposits and tissue abnormalities. It cannot always identify the precise product, its brand, the injected quantity or the date of treatment.

SECTION 01

Clinical Context & Referral Questions

REPORTED HISTORY

HISTORY

The patient has a reported history of previous facial injectable treatment. There is clinical concern regarding persistent injected material and/or chronic post-injection tissue alteration within the cheeks.

Product names, treatment dates, injected volumes and injection planes were not available at the time of this examination.

The current assessment identified multiple sonographically distinct soft-tissue abnormalities (regions of interest) within both cheeks, which are mapped and described in this report.

CLINICAL QUESTIONS

01	What abnormalities can currently be demonstrated and mapped by high-frequency ultrasound?
02	Do the identified lesions demonstrate the same or different sonographic phenotypes?
03	Is internal Doppler-detectable vascularity demonstrated?
04	Can the abnormalities be confidently characterised as a particular filler or material?
05	What further imaging or tissue characterisation may be useful?
06	Could the abnormalities potentially influence planning for future facial surgery?

PATIENT'S SURGICAL QUESTION

"The patient is also seeking advice regarding whether a future facelift could address or remove the identified abnormalities."

High-frequency ultrasound can map the location, depth and sonographic characteristics of the identified abnormalities; however, whether they are accessible or appropriate for removal during facelift surgery depends on their relationship to the surgeon's planned dissection plane, the surgical technique selected, the nature and extent of the material/tissue reaction, and adjacent anatomical structures. This question therefore requires assessment by the treating plastic surgeon. (See Section 10.)

SECTION 02

Ultrasound Technique & Stored Clip Record

TECHNIQUE

Bilateral cheek soft-tissue assessment using a Clarius L20 HD3 high-frequency linear transducer. B-mode imaging through the superficial and deeper soft-tissue planes, with colour Doppler where performed. Dynamic real-time assessment, including transducer compression where performed, and comparison between abnormal regions.

SETTINGS VISIBLE ON STORED CLIPS

Preset	FACIAL_CHEEK
Frequency	14.0 MHz (13–15 MHz band)
Depth	2.4 cm
Doppler	Colour box on selected clips

Depths quoted in this report are estimates read against the on-screen depth scale, not caliper measurements.

STORED CLIP RECORD

STORED IMAGE

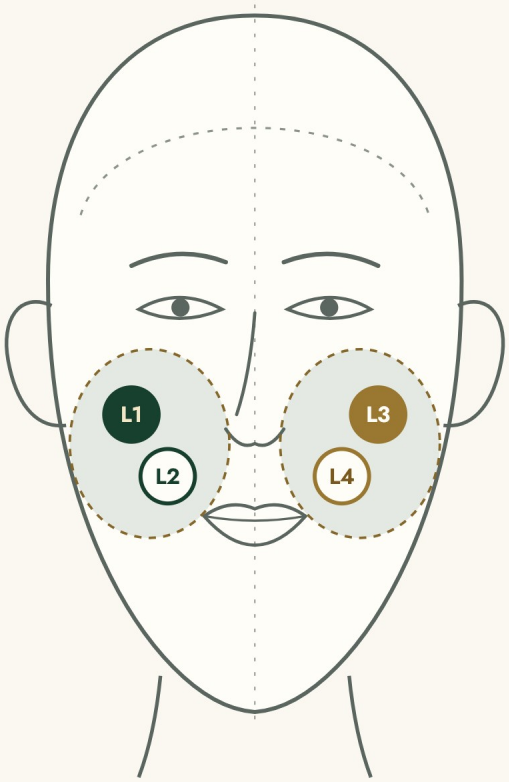
CAPTURED	LENGTH	MODE	ASSIGNED
10:37:38	13 s	B-mode	**L2 · Right**
10:40:14	30 s	B-mode; colour Doppler 22–29 s	**L1 · Right**
10:40:48	15 s	Colour Doppler	**L1 · Right**
10:55:55	5 s	Colour Doppler (duplicate store at 10:55:56)	**L3 · Left**
11:00:23	24 s	Colour Doppler	**L3 · Left**
11:01:00	27 s	Colour Doppler	**L3 · Left**
11:03:19	13 s	B-mode	**L4 · Left**

LATERALITY NOTE

The ultrasound probe pictogram was not consistently updated during acquisition. Lesion laterality in this report therefore follows the real-time examination record and confirmation of the examining physician rather than relying solely on the pictogram displayed on individual stored clips.

SECTION 03 · SIGNATURE MAP

Your Facial Map



Schematic anatomical map. Not to scale. Markers indicate the documented region; precise coordinates were not recorded.

MAPPED REGIONS OF INTEREST

L1 — PATIENT RIGHT CHEEK
Reniform / lymph-node-like appearance
Est. depth ~0.5–1.0 cm

L2 — PATIENT RIGHT CHEEK
Elongated hypoechoic band-like abnormality
Est. depth ~0.35–0.75 cm; deeper parallel component ~1.0–1.35 cm

L3 — PATIENT LEFT CHEEK
Heterogeneous lesion with markedly echogenic core
Est. depth ~0.6–1.75 cm; echogenic core ~1.0–1.65 cm

L4 — PATIENT LEFT CHEEK
Complex multiloculated hypoechoic abnormality
Est. depth ~0.3–1.2 cm

Depths are estimates read against the on-screen depth scale of the stored images, not caliper measurements. L3 is shown solid gold to mark its distinct sonographic appearance.

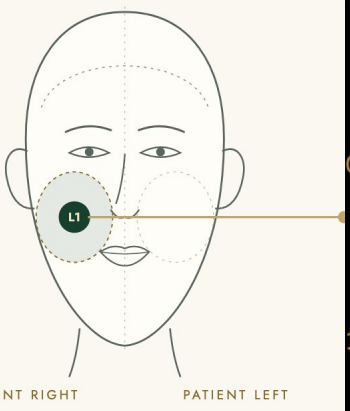
READING THE MAP

The face is drawn as if you are looking at the patient: the **patient's right cheek appears on the left of the page**. Within each cheek, the position of a marker is illustrative only — the marker shows which cheek the finding belongs to, not where in the cheek it lies. Relative placement of markers within a cheek carries no meaning.

SECTION 04 · LESION 1 · PATIENT RIGHT CHEEK

Reniform / Lymph-Node-Like Structure

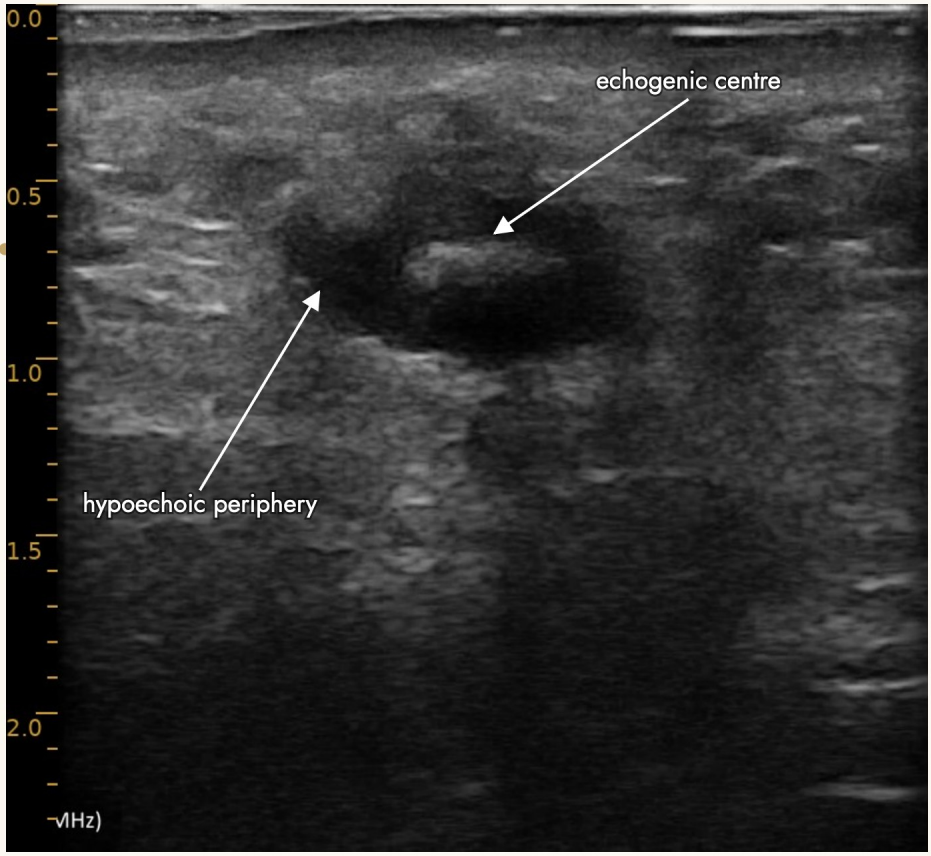
L1



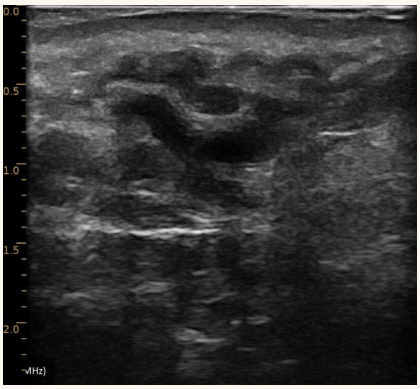
REGION REFERENCE

Patient right cheek

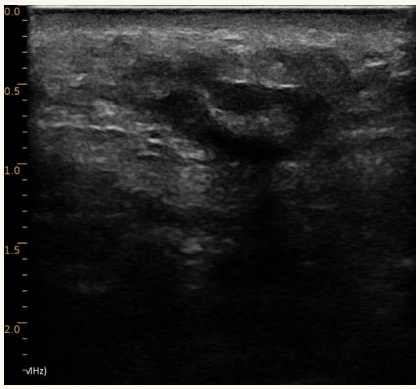
Schematic only. Precise coordinates within the cheek, scan angle and probe orientation were not recorded. Laterality follows the examination record and the examining physician's confirmation (see Laterality Note, Section 02).



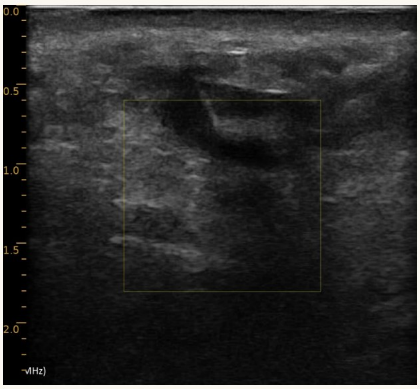
1A · B-mode · clip 10:40:14 · 6 s — clearest reniform plane



1C · B-mode · 8 s — lobulated outline



1D · B-mode · 16 s — crescentic rim, tapering core



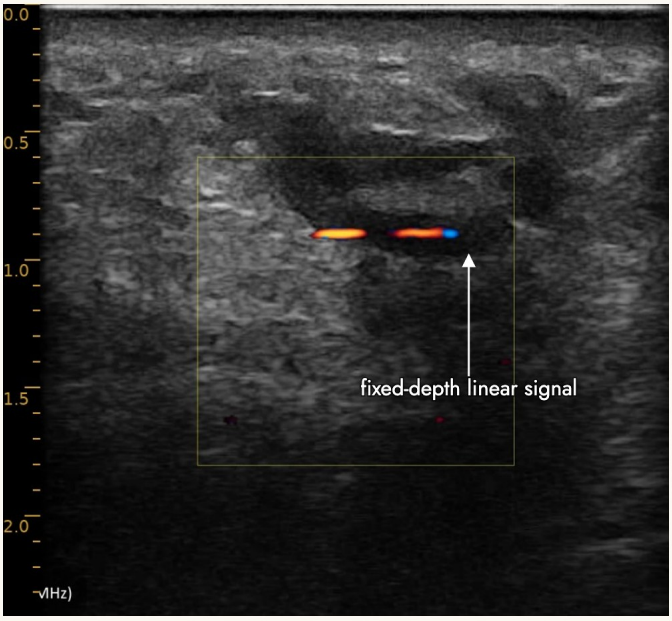
1E · Colour · clip 10:40:48 · 6 s — no colour in box

ESTIMATED DEPTH	CALIPER MEASUREMENTS	DOPPLER (REAL-TIME)	STORED CLIPS
~0.5–1.0 cm (read against on-screen scale)	None quoted in source report	Very weak hilar/deep signal; insufficient for a characteristic pattern	10:40:14 (30 s) · 10:40:48 (15 s)

SECTION 04 · LESION 1 · CONTINUED

Findings & Interpretation

L1



1B · Colour Doppler · clip 10:40:14 · 27 s — linear signal along deep portion

DOPPLER REAL-TIME

A very weak Doppler signal was observed in the hilar/deep region during real-time scanning; however, the signal was insufficient to confidently establish a characteristic hilar vascular pattern.

DOPPLER STORED IMAGE

Stored clips are not decisive: a fixed-depth linear signal (1B) and intervals without colour (1E) are both recorded.

STORED IMAGE FINDINGS STORED IMAGE

An ovoid-to-reniform, predominantly hypoechoic structure is demonstrated within the right cheek soft tissues. It demonstrates a reniform configuration with a relatively echogenic central component, producing a lymph-node-like appearance in some imaging planes (1A). Margins are well defined, with a hypoechoic peripheral component around an eccentric echogenic band, at approximately 0.5–1.0 cm depth. Morphology varies through the sweep — lobulated, ovoid, reniform and crescentic configurations (1C, 1D).

INTERPRETATION INTERPRETATION

The lymph-node-like appearance is a morphological description only. This morphology is not specific, and the nature of the structure remains indeterminate on ultrasound.

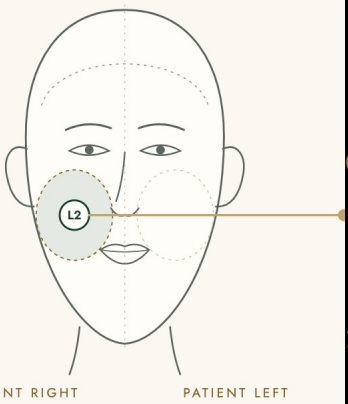
ALTERNATIVE CONSIDERATION

Because Lesion 1 and the elongated Lesion 2 occupy broadly similar depth ranges within the right cheek, an additional possibility is that Lesion 1 could represent a focal or cross-sectional configuration related to Lesion 2 or to another soft-tissue process, rather than a separate structure. Anatomical continuity was not established during this examination.

SECTION 05 · LESION 2 · PATIENT RIGHT CHEEK

Elongated Hypoechoic Band-Like Abnormality

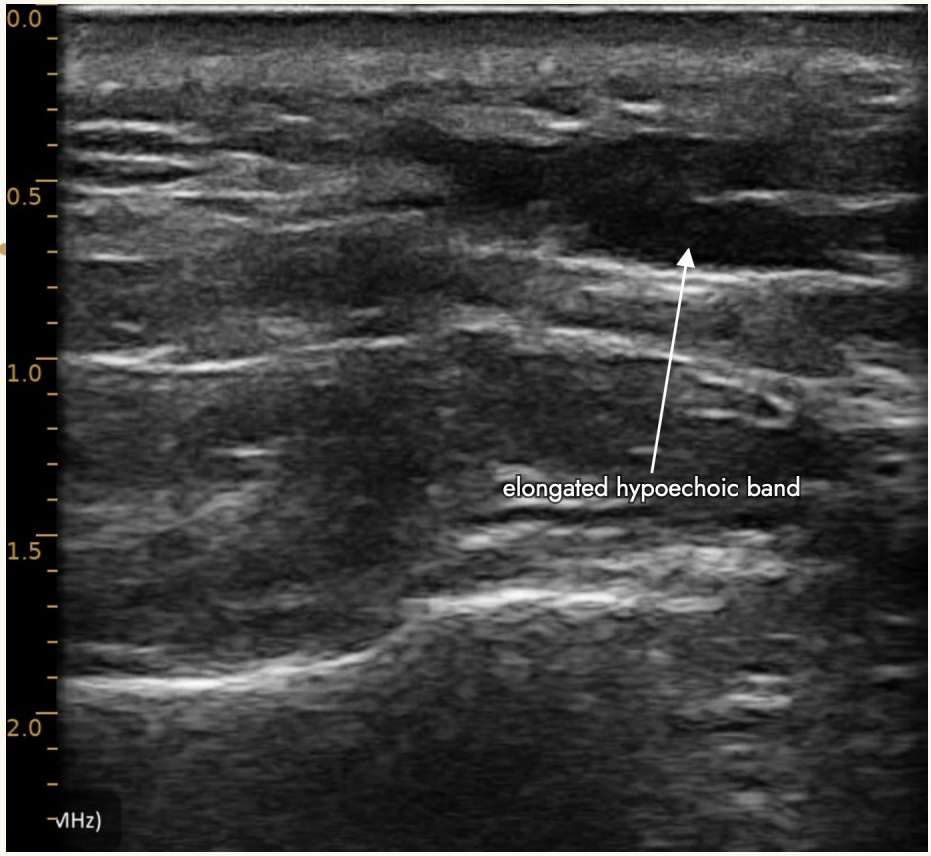
L2



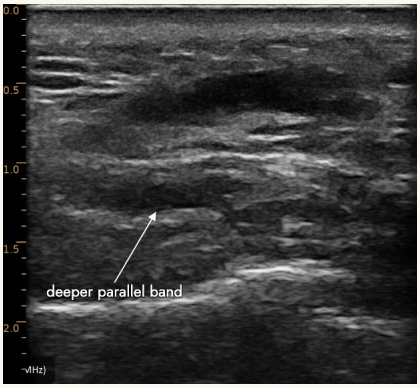
REGION REFERENCE

Patient right cheek

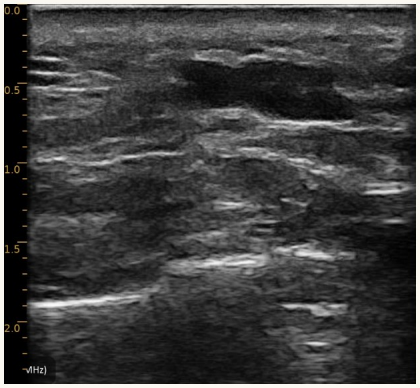
Schematic only. Precise coordinates within the cheek, scan angle and probe orientation were not recorded. Laterality follows the examination record and the examining physician's confirmation (see Laterality Note, Section 02).



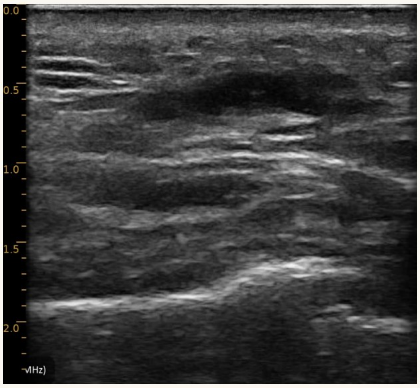
2A · B-mode · clip 10:37:38 · 0 s — band extends beyond field edge



2B · B-mode · 10 s — second, deeper parallel component



2C · B-mode · 4 s — band persists through sweep



2D · B-mode · 12 s — two parallel components

ESTIMATED DEPTH	CALIPER MEASUREMENTS	DOPPLER (REAL-TIME)	STORED CLIP
~0.35–0.75 cm; deeper parallel component ~1.0–1.35 cm	None quoted; full longitudinal extent not established	No internal vascularity detected; Doppler not stored	10:37:38 (13 s, B-mode)

SECTION 05 · LESION 2 · CONTINUED

Findings & Interpretation

L2

REAL-TIME · EXAMINING PHYSICIAN REAL-TIME

Compression
Non-compressible / not appreciably deformable with transducer pressure

Muscle movement
No appreciable movement or deformation with adjacent facial muscle activity

Colour Doppler
No internal vascularity detected

STORED IMAGE FINDINGS STORED IMAGE

A long, horizontally oriented, band-like hypoechoic to near-anechoic structure is demonstrated within the right cheek soft tissues at approximately 0.35–0.75 cm depth. The abnormality extends beyond the captured field in some frames, and its complete longitudinal extent is therefore not established.

Margins are relatively smooth, with low-level internal echoes and thin echogenic interfaces along its upper and lower borders. A deeper parallel hypoechoic component is shown at approximately 1.0–1.35 cm (2B, 2D). No convincing posterior shadowing; no snowstorm or reverberation pattern.

DOPPLER & INTERPRETATION INTERPRETATION

No internal vascularity was detected during real-time colour Doppler assessment. Absence of a detectable Doppler signal does not establish complete avascularity, particularly for very slow or low-volume flow. Doppler was not stored for this clip.

The elongated, predominantly hypoechoic, gel-like sonographic appearance is not specific. In the clinical context of previous facial injectable treatment, persistent injected material or chronic post-injection change are considerations; the nature of the structure cannot be determined on ultrasound alone.

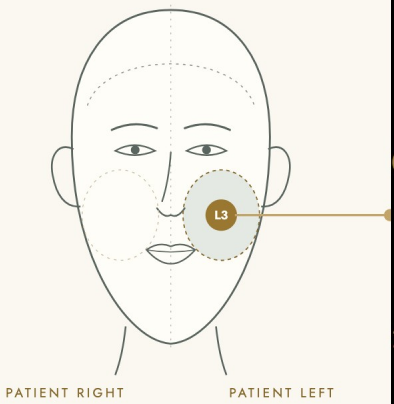
IMAGING CONSIDERATIONS ONLY

Long-standing hyaluronic acid · non-biodegradable hydrogel-type materials (e.g. polyacrylamide gel, polyalkylimide). Differential possibilities only; not a material identification.

SECTION 06 · LESION 3 · PATIENT LEFT CHEEK

Heterogeneous Lesion with Markedly Echogenic Core

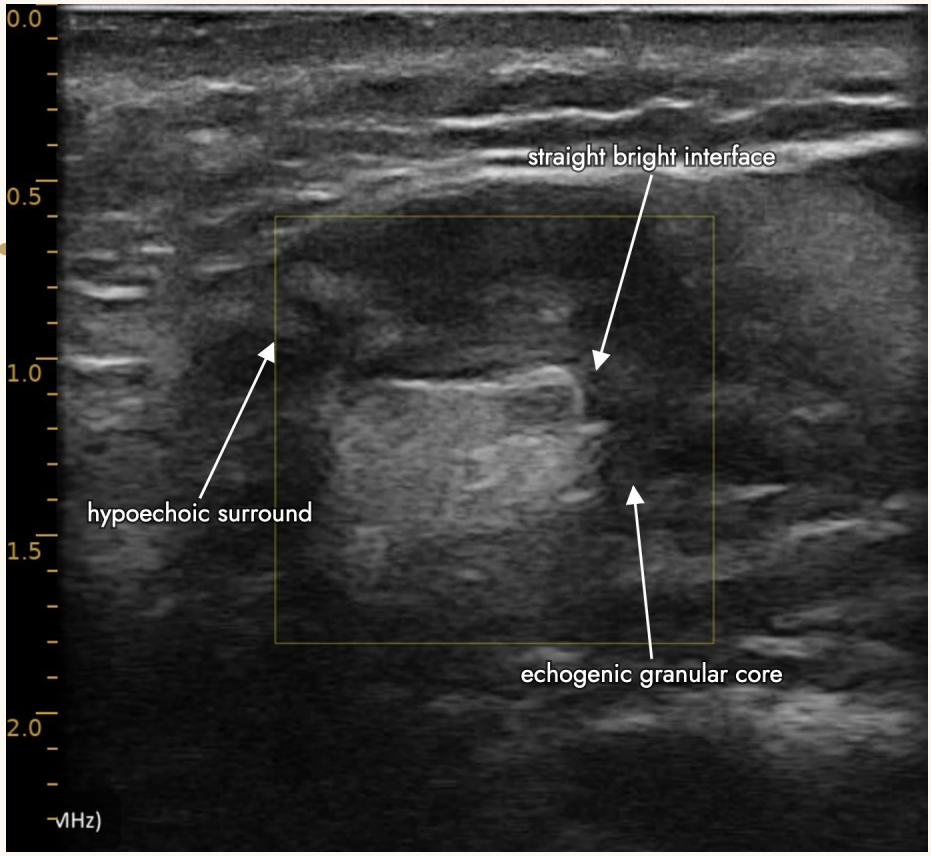
L3



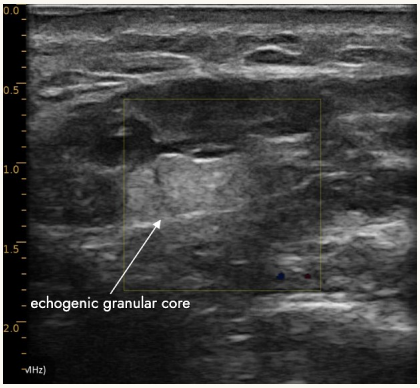
REGION REFERENCE

Patient left cheek

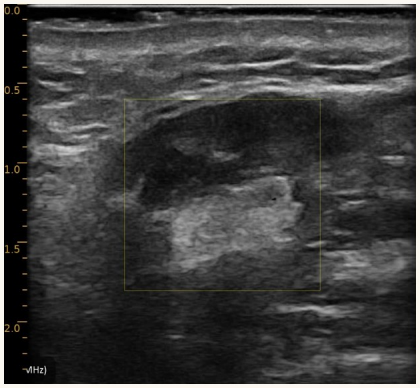
Schematic only. Precise coordinates within the cheek, scan angle and probe orientation were not recorded. Laterality follows the examination record and the examining physician's confirmation (see Laterality Note, Section 02).



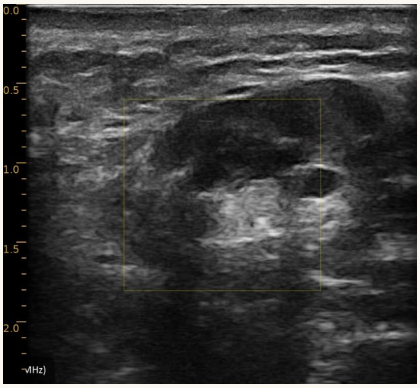
3A · B-mode (colour box) · clip 11:00:23 · 8 s



3B · B-mode (colour box) · clip 10:55:55 · 1 s



3C · clip 11:01:00 · 2 s — hypoechoic cap over core



3D · clip 11:01:00 · 12 s — dome-shaped cap

ESTIMATED DEPTH	CALIPER MEASUREMENTS	DOPPLER (REAL-TIME)	STORED CLIPS
~0.6–1.75 cm; echogenic core ~1.0–1.65 cm	None quoted in source report	No internal vascularity detected; stored flash artefact (see p. 14)	10:55:55 (5 s) · 11:00:23 (24 s) · 11:01:00 (27 s)

SECTION 06 · LESION 3 · CONTINUED

Findings & Clip Correlation

L3

STORED IMAGE FINDINGS STORED IMAGE

A heterogeneous soft-tissue abnormality is demonstrated within the left cheek. Lesion 3 demonstrates a distinctly different sonographic appearance, characterised by a markedly echogenic, finely granular central/deeper component associated with surrounding or superficial hypoechoic tissue.

A sharp, straight bright interface is visible along the upper surface of the echogenic component in several frames (3A). The abnormality spans approximately 0.6–1.75 cm depth, with the echogenic core at approximately 1.0–1.65 cm. Mild posterior attenuation in some frames; no dense shadow.

CLIP CORRELATION STORED IMAGE

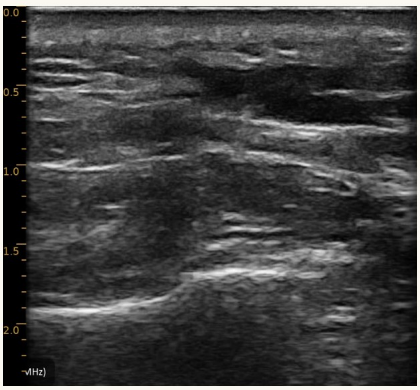
Three left-cheek clips (10:55, 11:00 and 11:01) show a closely similar phenotype. Anatomical continuity between them cannot be proven from the stored images; they are grouped here as Lesion 3 on the basis of shared appearance and the examination record.

Of the abnormalities identified in this examination, Lesion 3 is the most morphologically distinct and may warrant particular attention on cross-sectional imaging and, if clinically indicated, tissue characterisation.

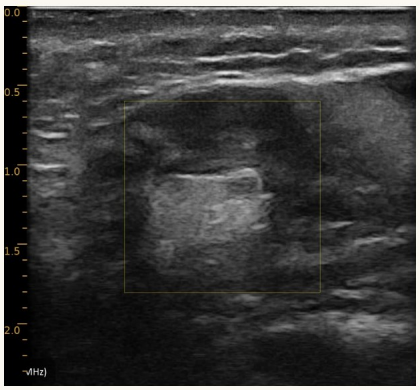
DISTINCT SONOGRAPHIC PHENOTYPE

Lesion 3 differs substantially from the predominantly hypoechoic, gel-like appearance of Lesions 2 and 4 because of its markedly echogenic granular component.

PHENOTYPE CONTRAST · SAME SCALE, SAME SETTINGS STORED IMAGE



L2 · hypoechoic band (frame 2A)



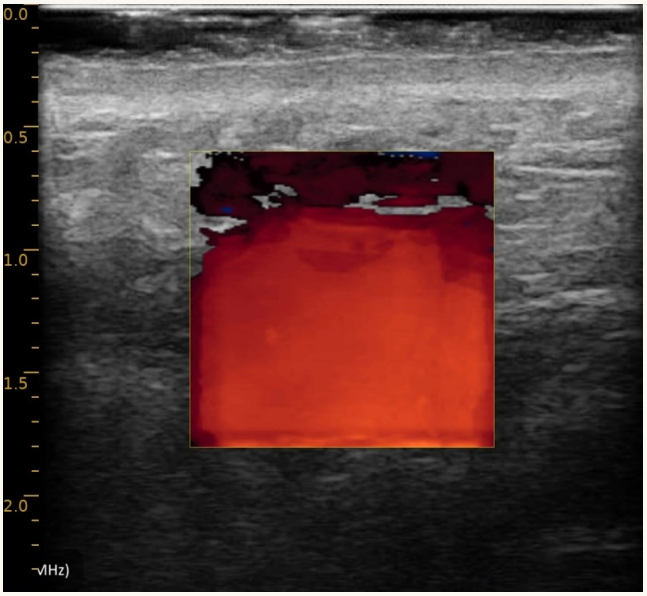
L3 · echogenic granular core (frame 3A)



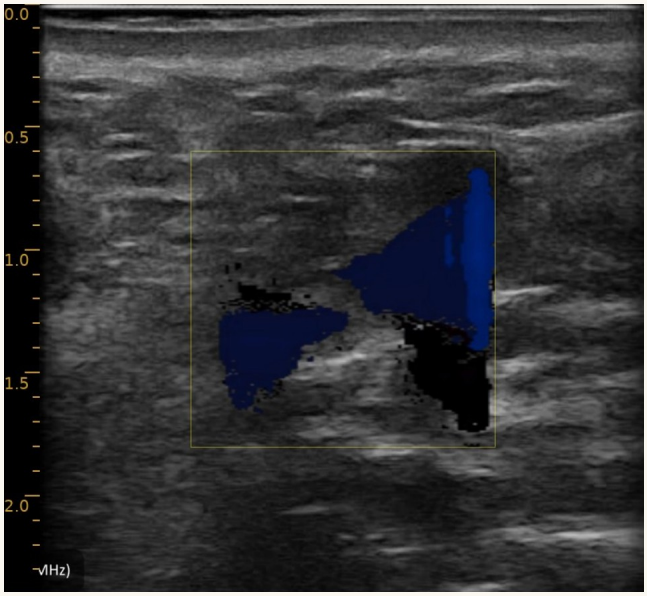
L4 · complex hypoechoic (frame 4A)

SECTION 06 · LESION 3 · CONTINUED

Doppler Observations & Imaging Differential L3



3E · Colour · clip 11:00:23 · 1 s — whole-box flash artefact



3F · Colour · clip 11:01:00 · 5 s — single-second motion/flash pattern

DOPPLER REAL-TIME

No internal vascularity was detected by the examining physician during real-time Doppler assessment.

DOPPLER ARTEFACT STORED IMAGE

Some stored colour frames contain flash/motion artefact — large smooth-edged colour blocks filling the colour box for a single second, including over solid echogenic tissue (3E, 3F). These should not be interpreted as genuine diffuse lesion vascularity. Absence of a detectable signal does not establish complete avascularity.

INTERPRETATION INTERPRETATION

In the clinical context of previous facial injectable treatment, this appearance raises consideration of injected material and/or an associated chronic tissue response. Particulate or biostimulatory materials and foreign-body/fibrotic/granulomatous reactions are among the differential considerations; however, ultrasound cannot establish material composition or histological tissue response.

DIFFERENTIAL CONSIDERATIONS INTERPRETATION

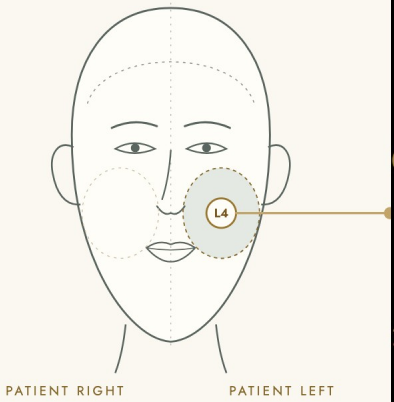
Particulate biostimulatory material	class
Poly-L-lactic acid (PLLA)	pattern
Calcium hydroxylapatite (CaHA)	pattern
Polymethyl methacrylate (PMMA)	pattern
Foreign-body / fibrotic / granulomatous response	reaction
Non-filler soft-tissue mimics	possible

Non-ranked, pattern-based considerations — not material identification. None is favoured as a leading diagnosis.

SECTION 07 · LESION 4 · PATIENT LEFT CHEEK

Complex Multiloculated Hypoechoic Abnormality

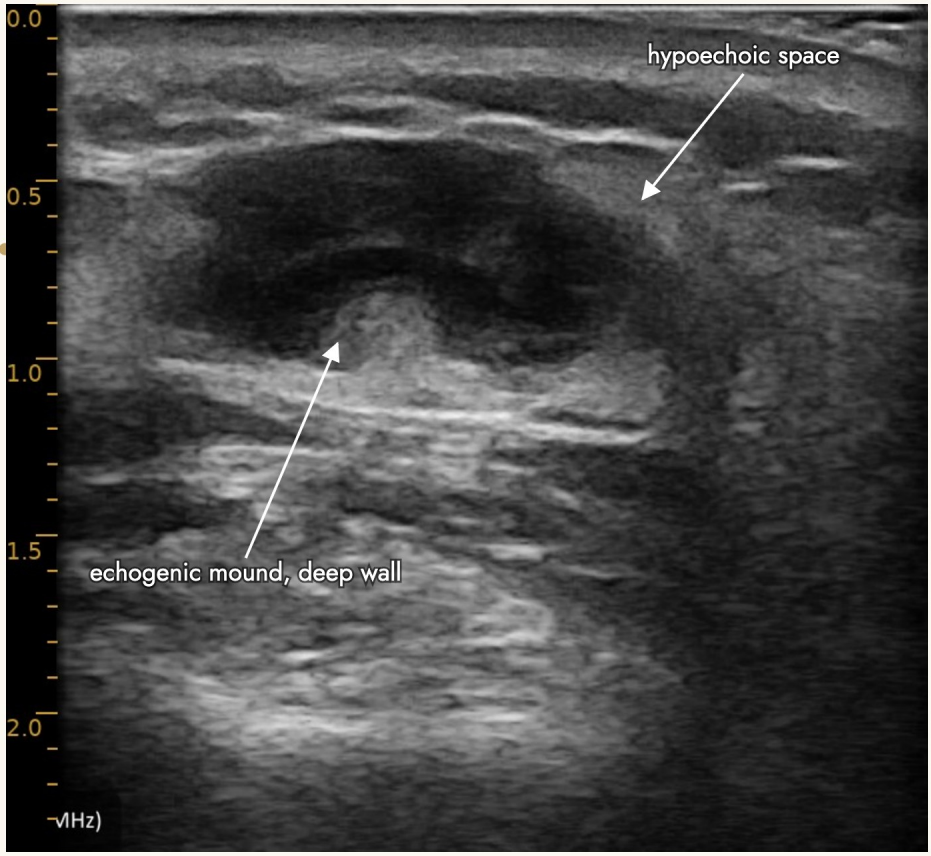
L4



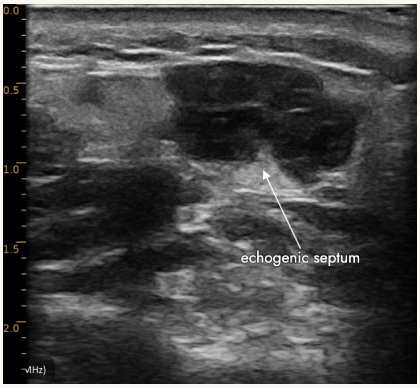
REGION REFERENCE

Patient left cheek

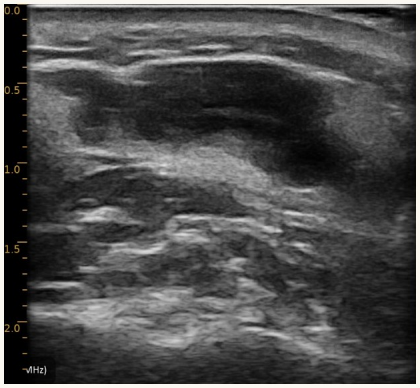
Schematic only. Precise coordinates within the cheek, scan angle and probe orientation were not recorded. Laterality follows the examination record and the examining physician's confirmation (see Laterality Note, Section 02).



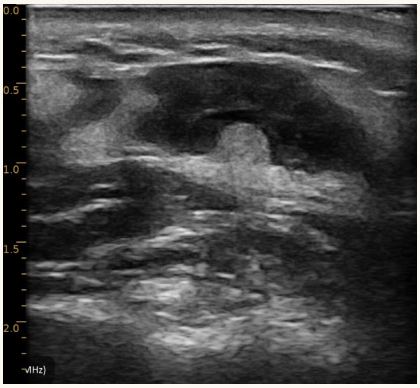
4A · B-mode · clip 11:03:19 · 5 s



4B · B-mode · 10 s — lobulated spaces with echogenic wedge



4C · 2 s — elongated curved component



4D · 8 s — mound in floor, thin septum

ESTIMATED DEPTH	CALIPER MEASUREMENTS	DOPPLER (REAL-TIME)	STORED CLIP
~0.3–1.2 cm	None quoted in source report	No internal vascularity detected; Doppler not stored	11:03:19 (13 s, B-mode)

SECTION 07 · LESION 4 · CONTINUED

Findings & Interpretation

L4

REAL-TIME · EXAMINING PHYSICIAN REAL-TIME

Colour Doppler
No internal vascularity detected

Compression
Not separately documented for this lesion in the stored record

STORED IMAGE FINDINGS STORED IMAGE

A complex, predominantly hypoechoic structure is demonstrated within the left cheek at approximately 0.3–1.2 cm depth. It shows clustered, lobulated hypoechoic spaces separated by thin echogenic septa (4B, 4D), with an echogenic mound-like projection arising from the deep wall (4A) and elongated, partly tubular components (4C). A separate deeper hypoechoic area is seen in some frames.

No internal vascularity was detected during real-time Doppler assessment; Doppler was not stored for this clip.

INTERPRETATION INTERPRETATION

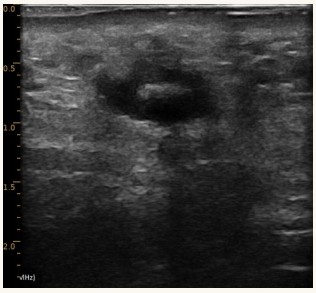
The structure has a predominantly hypoechoic, gel-like sonographic appearance with internal septation and mural echogenic components. L2 and L4 share some sonographic features, particularly their predominantly hypoechoic appearance; however, L4 demonstrates greater internal complexity. Whether they represent the same material/process, different stages of one process, or unrelated abnormalities cannot be established by ultrasound.

CONSIDERATIONS

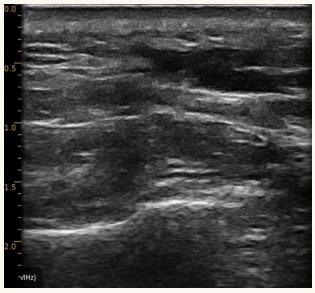
Differential possibilities only: chronic HA-related change · non-degradable hydrogel · chronic post-injection collection or material · associated fibrosis or foreign-body reaction · unrelated soft-tissue abnormality.

SECTION 08

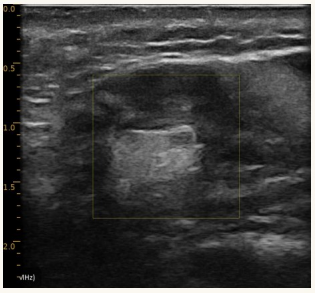
Comparative Lesion Analysis



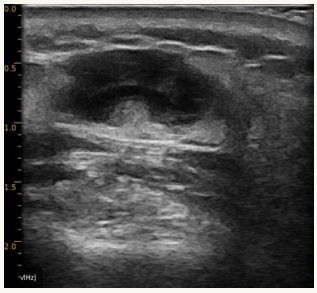
L1 · Right



L2 · Right



L3 · Left · distinct



L4 · Left

LESION	SIDE	MORPHOLOGY	ECHOGENICITY	DYNAMIC	DOPPLER	RELATIVE INTERPRETATION
L1	Right	Reniform/ovoid, central echogenic band	Predominantly hypoechoic with echogenic centre	Not separately documented	Very weak, indeterminate hilar-area signal	Node-like but indeterminate
L2	Right	Elongated, band-like; deeper parallel component	Hypoechoic to near-anechoic	Non-compressible; no movement with muscle activity	No internal flow detected in real time	Predominantly hypoechoic, gel-like appearance; indeterminate
L3	Left	Heterogeneous with granular core; straight bright interface	Markedly echogenic core + hypoechoic surround	Not separately documented	No internal flow detected in real time; stored flash artefact	Distinct echogenic/particulate-appearing phenotype; indeterminate
L4	Left	Complex, multiloculated, septated	Predominantly hypoechoic with echogenic components	Not separately documented	No internal flow detected in real time	Complex, predominantly hypoechoic appearance; indeterminate

Real-time Doppler findings are the examining physician's observations. Non-detection of flow does not establish avascularity.

KEY COMPARATIVE OBSERVATION

The abnormalities should not be assumed to represent one uniform material or process. Lesions 2 and 4 share a predominantly hypoechoic, gel-like appearance, although Lesion 4 is more internally complex. Lesion 3 is distinctly different because of its markedly echogenic granular component. Lesion 1 has a separate reniform, lymph-node-like appearance of indeterminate nature.

SECTION 09

Sonographic Differential Considerations

High-frequency ultrasound can characterise morphology, depth, echogenicity, dynamic behaviour and Doppler findings, but there is substantial overlap between the appearances of different historical injectable materials and chronic tissue reactions.

INTERPRETATION

	CATEGORY	RELEVANT TO	PATTERN BASIS AND LIMITS
1	**Persistent HA / chronic HA-related deposits**	L2 · L4	Hypoechoic appearances; long-standing HA may appear hypoechoic or cloud-like rather than anechoic. Overlaps with hydrogels on greyscale.
2	**Non-biodegradable hydrogels — PAAG/polyacrylamide or polyalkylimide**	L2 · L4	Anechoic/hypoechoic, globular or cystic-looking patterns shared with HA. Fibrous capsule described histologically, not demonstrable by ultrasound.
3	**Particulate / biostimulatory materials — PLLA, CaHA, PMMA**	L3	Echogenic deposits; shadowing varies with dilution; comet-tail artefact described for PMMA, not seen here. These materials overlap with each other.
4	**Chronic foreign-body, fibrotic or granulomatous tissue response**	L3 · L4	Hypoechoic tissue surrounding an echogenic focus is a published pattern; material-nonspecific. Confirmation requires histology.
5	**Less likely non-injection-related soft-tissue lesions / mimics**	L1 · L3	Includes a true facial lymph node for L1 and adnexal-type lesions for L3. Cannot be excluded on ultrasound appearance alone.

These categories represent pattern-based imaging considerations rather than diagnoses and are not ranked. Considerable sonographic overlap exists between injectable materials and chronic tissue responses, and individual appearances may vary according to material, age, tissue plane and biological response.

FREE LIQUID SILICONE

The classic snowstorm appearance with dirty posterior shadowing was not demonstrated on these images. This makes free liquid silicone less characteristic but does not exclude it.

WHAT ULTRASOUND CANNOT DETERMINE

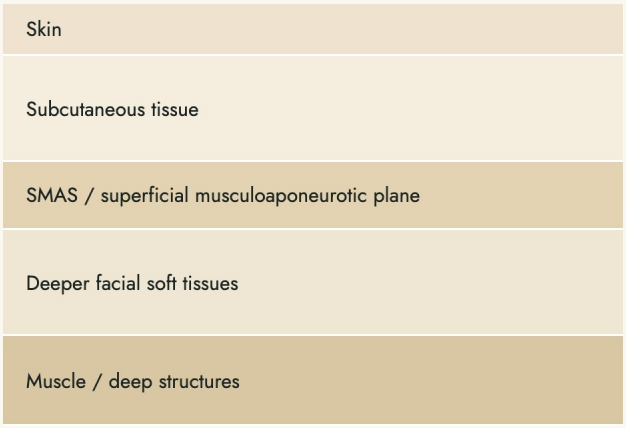
The specific injected product(s); whether lesions share one material; the presence of a capsule or granuloma; or complete avascularity. Categories above are not ranked and carry no probability.

SECTION 10 · LAYER & SURGICAL RELEVANCE

Surgical Planning Considerations

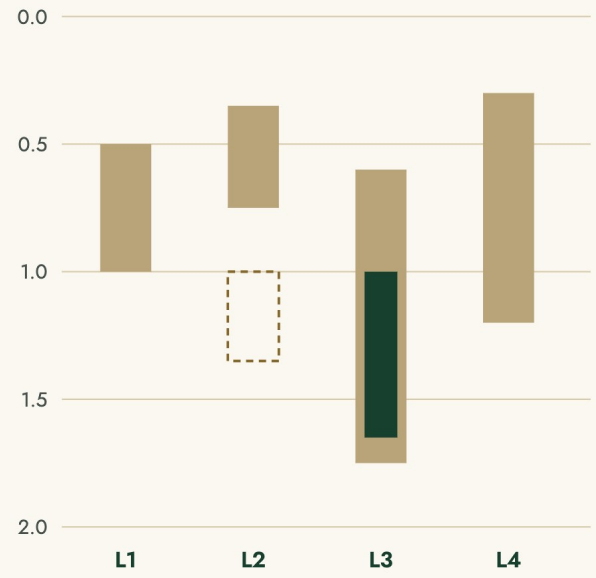
The identified abnormalities are not confined to a single uniform superficial plane. They are demonstrated at differing depths within the cheek soft tissues.

FACIAL SOFT-TISSUE LAYERS · SCHEMATIC — NOT TO SCALE



Layer thickness varies by individual and site. Lesions are not assigned to named surgical planes in this report.

APPROXIMATE DEPTH FROM SKIN (CM) · SCHEMATIC — NOT TO SCALE



Approximate depth ranges derived from stored ultrasound images; not anatomical assignment to a surgical plane. Not aligned to the layer diagram. L2 dashed: deeper parallel component. L3 dark: echogenic core.

CAN A FACELIFT REMOVE THESE ABNORMALITIES?

The patient has asked whether facelift surgery could simultaneously address the identified abnormalities. The ultrasound findings alone cannot answer this question.

The abnormalities are distributed at differing tissue depths and are not necessarily all located within the tissue plane that would be entered or elevated during a particular facelift technique. A facelift is not a single standardised dissection: the operative plane and extent vary according to the technique selected and the individual surgeon's approach. Consequently, some abnormalities may potentially be encountered or accessible during surgical dissection, while others may lie outside the planned plane, may be intimately associated with surrounding tissue, or may not be safely removable without additional targeted dissection.

The feasibility, completeness and safety of removal must therefore be determined by the treating plastic surgeon after review of the imaging, clinical examination and, where appropriate, MRI.

SECTION 10 · CONTINUED

Questions for the Plastic Surgeon

Prepared to support the consultation with the treating plastic surgeon and posed for the surgeon's judgement. RECOMMENDATION

01	Which mapped abnormalities fall within or adjacent to the intended surgical dissection plane?	02	Which, if any, are safely accessible?
03	Would attempted removal increase risk to facial nerve branches, parotid duct, vascular structures or skin-flap viability?	04	Would targeted removal be attempted concurrently or separately?
05	If tissue/material is removed, should samples be sent for histopathology ± microbiology/material analysis?	06	Would preoperative ultrasound marking be useful on the day of surgery?

SECTION 11

Recommended Further Characterisation

Ultrasound has identified morphologically different abnormalities but cannot reliably establish material composition. MRI may provide complementary information on intrinsic signal characteristics, peri-lesional tissue response and anatomical relationships.

SUGGESTED RECOMMENDATION RECOMMENDATION

MRI of the face may be considered for further soft-tissue characterisation, anatomical correlation and, if relevant, preoperative planning.

The appropriate MRI protocol, including the use of intravenous contrast, should be determined by the consultant radiologist according to the clinical question.

QUESTIONS FOR THE CONSULTANT RADIOLOGIST

01	Do Lesions 2, 3 and 4 demonstrate similar or different T1/T2 signal characteristics?
02	Does the central component of Lesion 3 differ substantially from the other abnormalities?
03	Is there evidence of a capsule or pseudocapsule?
04	Is there surrounding fibrosis or enhancement?
05	Is there nodular or diffuse peri-lesional enhancement?
06	Are parotid or cervical lymph nodes abnormal? Is Lesion 1 separate from, or continuous with, Lesion 2?
07	What are the relationships of the abnormalities to the SMAS, buccal fat, masseter, parotid gland/duct and other relevant structures?
08	Is there evidence of migration along tissue planes?
09	Would CT be useful if calcification is suspected?
10	Would any lesion, particularly Lesion 3, merit image-guided biopsy or histological assessment?

Questions 09 and 10 are posed to the radiologist and clinical team for their judgement; they are not instructions to the patient.

SECTION 12

Impression

01 Several sonographically distinct soft-tissue abnormalities are demonstrated in both cheeks, mapped as four regions of interest (L1–L4) with differing morphology.

02 Right-cheek Lesion 1 demonstrates a reniform configuration with a relatively echogenic central component, producing a lymph-node-like appearance in some planes. A very weak hilar/deep Doppler signal was observed in real time but was insufficient to establish a characteristic vascular pattern. The nature of the structure remains indeterminate on ultrasound.

03 Right-cheek Lesion 2 is an elongated, predominantly hypoechoic to near-anechoic band-like abnormality with a gel-like sonographic appearance.

04 Left-cheek Lesion 3 demonstrates a distinctly different sonographic appearance, characterised by a markedly echogenic granular component associated with surrounding hypoechoic tissue.

05 Left-cheek Lesion 4 demonstrates a complex, predominantly hypoechoic, multiloculated/septated appearance with echogenic internal/mural components. It shares some features with Lesion 2 but is more internally complex.

06 No internal vascularity was detected in Lesions 2–4 during the examining physician's real-time Doppler assessment. This should not be interpreted as proof of complete avascularity.

07 The differing appearances may reflect different materials, different biological responses to previous treatment, different stages of one process, or potentially unrelated soft-tissue abnormalities; they should not be assumed to represent one uniform material or process.

08 In the clinical context of previous facial injectable treatment, the findings raise consideration of persistent injected material and/or chronic post-injection tissue change; however, material composition and histology cannot be established by ultrasound alone.

09 Further radiological and surgical correlation, including MRI where clinically appropriate, may help address the remaining questions regarding tissue characterisation, anatomical relationships and surgical planning.

10 The mapped abnormalities are demonstrated at differing soft-tissue depths and cannot be assumed to lie within a single surgical dissection plane. Whether any of these areas would be encountered, accessible or appropriate for removal during a future facelift procedure cannot be determined from ultrasound alone and requires assessment by the treating plastic surgeon.

Impression prepared by the examining physician. Consultant radiologist review: not documented for this sample (Section 15).

SECTION 13

Clinical Recommendations

Given the multiplicity, differing sonographic appearances and variable depths of the mapped abnormalities, empiric injection or dissolution based solely on presumed filler identity would not be advisable without further clinical and imaging correlation.

RECOMMENDATION

- Obtain previous injection and product records where possible.
- Consider MRI of the face, preferably with and without intravenous contrast, with final protocol at the consultant radiologist's discretion.
- Plastic-surgery assessment if surgical removal or facelift is being considered.
- Consider targeted tissue diagnosis if clinically/radiologically indicated, particularly for a lesion whose phenotype remains distinct or unexplained.
- If any material is surgically removed, histopathological analysis should be considered.
- Preoperative ultrasound mapping/skin marking may be useful if the surgeon elects to target a specific mapped abnormality.

IMPORTANT PRECAUTIONS · PART OF YOUR FUTURE TREATMENT PLAN

- Empiric injection or dissolution based solely on presumed filler identity would not be advisable without further clinical and imaging correlation.
- The abnormalities should not be assumed to represent one uniform material or process.
- Non-detection of Doppler flow does not establish avascularity.
- The mapped abnormalities cannot be assumed to lie within a single surgical dissection plane; whether any could be removed during a facelift requires assessment by the treating plastic surgeon.

SECTION 14 · SIGNATURE PLAN

Your Future Treatment Plan

Drawn exclusively from the recommendations documented in Sections 11 and 13. No new treatment, schedule or outcome is introduced.

PRIORITY 1

What needs clarification

Relevant further imaging, assessment or review

- Obtain previous injection and product records where possible.
- Consider MRI of the face, preferably with and without intravenous contrast, with final protocol at the consultant radiologist's discretion — for further soft-tissue characterisation, anatomical correlation and, if relevant, preoperative planning.
- Consider targeted tissue diagnosis if clinically/radiologically indicated, particularly for a lesion whose phenotype remains distinct or unexplained. Lesion 3 is the most morphologically distinct abnormality and may warrant particular attention on cross-sectional imaging and, if clinically indicated, tissue characterisation.

PRIORITY 2

What needs specialist input

Consultant radiologist, plastic surgeon or other appropriate clinician where indicated

- **Consultant radiologist** — MRI protocol, and the ten questions listed in Section 11.
- **Plastic surgeon** — assessment if surgical removal or facelift is being considered, including the questions listed in Section 10.
- If any material is surgically removed, histopathological analysis should be considered.
- Preoperative ultrasound mapping/skin marking may be useful if the surgeon elects to target a specific mapped abnormality.

PRIORITY 3

What can be considered later

Future aesthetic treatment planning

Future aesthetic treatment planning may be considered once the clinical and imaging assessment above is complete. No specific aesthetic treatment was recommended in the source report.

IMPORTANT PRECAUTIONS

Listed with the clinical recommendations on page 22 — please read them before any further treatment.

FOLLOW-UP

Review timing and **what to monitor**: not specified in the source report. **Further investigation**: as set out in Sections 11 and 13.

Review date _____

Reviewing clinician _____

SECTION 15

Review & Sign-off

CONSULTANT RADIOLOGIST REVIEW

NOT DOCUMENTED FOR THIS SAMPLE

Dr Abdul Rahman Alvi

MRCS, FRCR, CCT (UK) · Consultant Vascular & Interventional Radiologist

Independent interpretation

Additional findings or amendments

Recommendations

Review date

Signature

CLINICAL ASSESSMENT & TREATMENT PLANNING

UNSIGNED SAMPLE

Dr Shiva Faramarzi, MD

Aesthetic Physician · Examining Physician

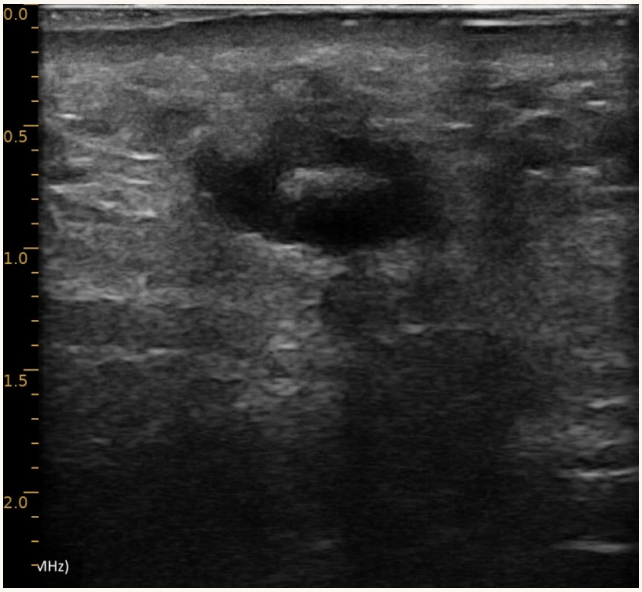
Date

Signature

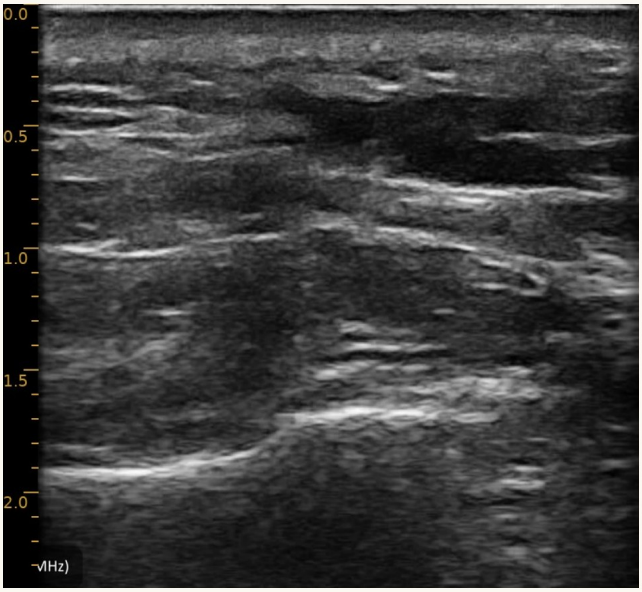
The consultant radiologist's imaging interpretation and the examining physician's clinical treatment recommendations are recorded separately. This anonymised sample has not been signed and is not presented as clinically approved.

APPENDIX

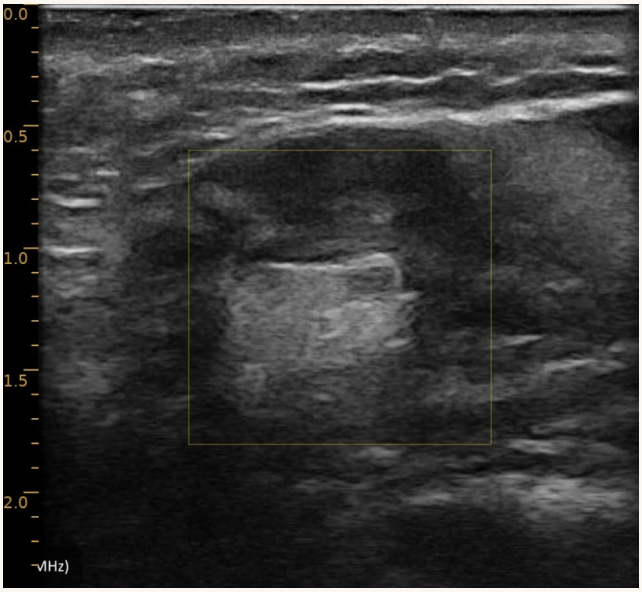
Representative Image Atlas



L1 — Right — reniform / node-like · 10:40:14 · 6 s



L2 — Right — elongated hypoechoic · 10:37:38 · 0 s



L3 — Left — heterogeneous echogenic core · 11:00:23 · 8 s



L4 — Left — complex multiloculated · 11:03:19 · 5 s

All frames: Clarius L20 HD3 · FACIAL_CHEEK preset · 14 MHz · depth 2.4 cm · depth scale (cm) at left of each frame. Frames cropped from stored clips; image content unaltered. Annotation arrows elsewhere in this report are overlaid on the page and do not alter the stored image.



THE AESTHETIC PASSPORT

Your face. Your history. Your future.

The Aesthetic Passport is a personalised clinical record. It is designed to support your future decisions and to help any treating physician understand what was assessed, what was found, and what remains to be clarified.

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Sample edition 1.0