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PHYSICIAN'S CLINICAL GUIDE

MIGLOU™

HIRONIC

Physician’s Clinical Guide

Let me glow, MIGLOU

DISCLAIMER

(Additional Explanation)

The treatment guidelines suggested in this Physician's Clinical Guide are based on various clinical studies, academic papers, and a range of cases. The parameters for the intended procedure must be adjusted according to individual cases. The manufacturer is not responsible for issues arising from improper use of the equipment or excessive treatment.

Before using the equipment, the practitioner must check the user manual, understand the accurate operation and handling of the equipment, and then proceed with the treatment. The treatment protocol includes patient history assessment and lesion diagnosis during pre-treatment consultation, treatment process, number of sessions, expected treatment outcomes, potential side effects, pre- and post-treatment precautions for both practitioners and patients, patient disclosure, selection of appropriate treatment variables according to the treatment purpose, post-treatment care, medication prescriptions, and scheduling follow-up visits.

The indications and parameters introduced in this booklet may be updated based on various clinical cases and treatment experiences. Practitioners are advised to refer to the latest insights for clinical application.

01

Introduction

In the medical and aesthetic fields, the demand for non-invasive treatments has continued to grow, with particular focus on the improvement of localized adiposity and skin laxity.

With aging, the skin and subcutaneous tissues undergo gradual changes. Reduced collagen synthesis and weakened structural support lead to decreased skin elasticity and tissue sagging, which are further influenced by gravity.

In this context, microwave-based technology is applied to deliver energy selectively to subcutaneous tissues in a non-invasive manner, targeting localized fat reduction and skin tightening.

1.1 Skin lifting / Face lifting / Skin Laxity

Skin laxity refers to the gradual loss of structural integrity and elasticity of the skin, a primary clinical manifestation of intrinsic and extrinsic aging. Unlike localized adiposity, skin laxity is characterized by the degradation of the extracellular matrix (ECM) and the weakening of the supportive connective tissues.

This condition is primarily driven by the quantitative and qualitative decline of collagen and elastin fibers within the dermis. As fibroblasts become less active with age, the production of Type I and Type III collagen decreases, leading to a thinner dermis and a loss of the "recoil" capacity of the skin. Clinically, this manifests as sagging, fine lines, and a loss of defined contours, particularly along the jawline (jowls), nasolabial folds, and the periorbital region.

Face lifting in a non-invasive context involves targeting not only the deep dermis but also the Superficial Musculoaponeurotic System (SMAS) and the fibrous septa within the subcutaneous layer. Effective lifting requires the delivery of controlled thermal energy to induce immediate collagen fiber contraction (shrinkage) and a subsequent wound-healing response known as neocollagenesis.

The application of energy-based devices in these areas aims to restore the structural tension of the skin. By promoting the remodeling of the dermal framework and tightening the septal networks, it is possible to achieve a visible elevation of facial tissues and a reduction in skin redundancy, thereby reversing the gravitational effects associated with skin laxity.

1.2 Adipocyte Cells and Localised Adiposity

Localized adiposity refers to fat accumulation confined to specific anatomical areas, in contrast to the generalized fat distribution observed in obesity. These deposits typically develop in regions where adipose tissue is physiologically present

In males, common areas include the lateral abdomen (often referred to as “love handles”), whereas in females, fat accumulation is more frequently observed in the hips, buttocks, thighs, and the medial aspect of the knees. Fat in these regions is generally less responsive to lifestyle interventions such as diet and exercise.

Adipocytes in these areas are influenced by hormonal factors, particularly through estrogen receptors, which play a role in regulating fat distribution and accumulation. This hormonal influence may contribute to the relative resistance of these localized fat deposits to reduction.

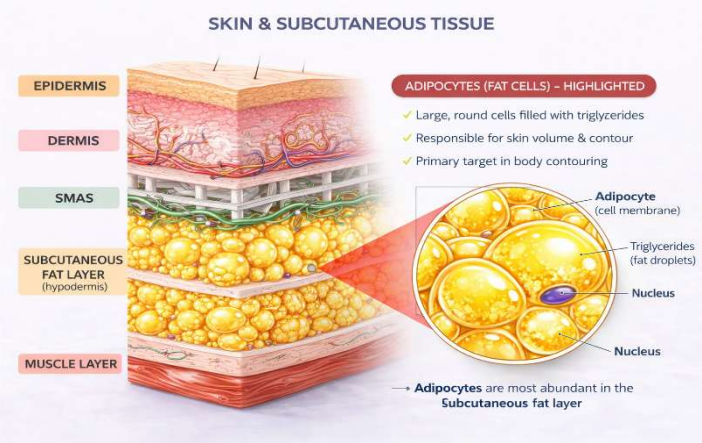


Figure 1. Structure of skin tissue and fat cell.

These localized fat deposits are primarily associated with an increase in adipocyte size (hypertrophy), becoming more pronounced as fat accumulation progresses. On palpation, the affected area typically feels firm, while pain is generally not present.

In addition, localized adipose tissue may be observed in conjunction with cellulite (Oedematous Fibrosclerotic Panniculopathy) within the same region.

1.2.1 Gynoid Morphotype

The gynoid morphotype is characterized by a relatively wider hip structure compared to the shoulders (bitrochanteric diameter exceeding the bi-humeral diameter), with a predominance of subcutaneous fat distribution in the lower body.

Fat accumulation is typically observed in the lower abdomen below the umbilical level, the trochanteric region, buttocks, the distal third of the thighs, and the medial area above the knees.

This pattern is commonly referred to as a “pear-shaped” body type and is generally associated with a female pattern of fat distribution, influenced by female sex hormones.

1.2.2 Android Morphotype

The android morphotype is defined by a predominance of subcutaneous fat deposition in the upper body. Common areas of accumulation include the chest, lower cervical region, posterior upper arms (tricipital area), and abdomen.

This distribution pattern is typically associated with a male-type fat distribution and is often described as an “apple-shaped” body type. However, it may also be present in females, particularly after menopause.

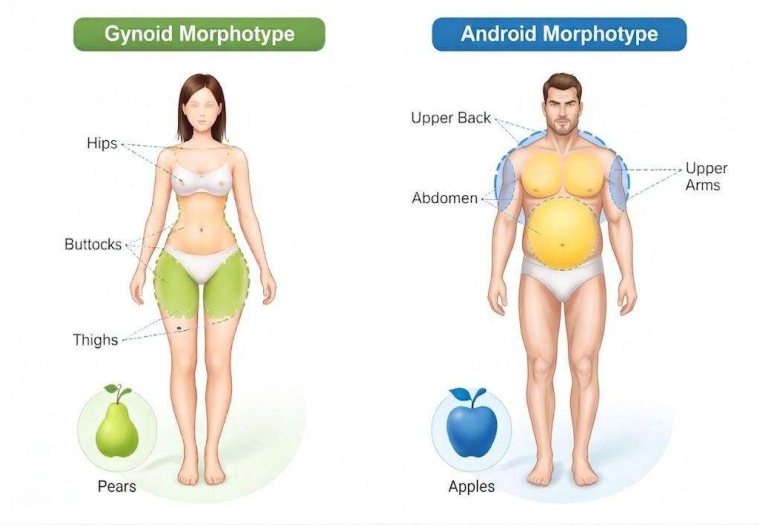


Figure 2. Gynoid & Android Morphotype

1.3 Oedematous Fibrosclerotic Panniculopathy (Cellulite)

Clinically defined as Oedematous Fibrosclerotic Panniculopathy (EFP), cellulite represents structural and aesthetic alterations within the subcutaneous adipose tissue. While predominantly identified in gynoid-type subjects, it specifically localizes in the trochanteric region, the supero-lateral aspects of the thighs, the medial knee, and the gluteal area. A key clinical characteristic is its latency; the irregular skin texture may remain invisible while the tissue is relaxed, becoming apparent only upon manual compression or mechanical stress.

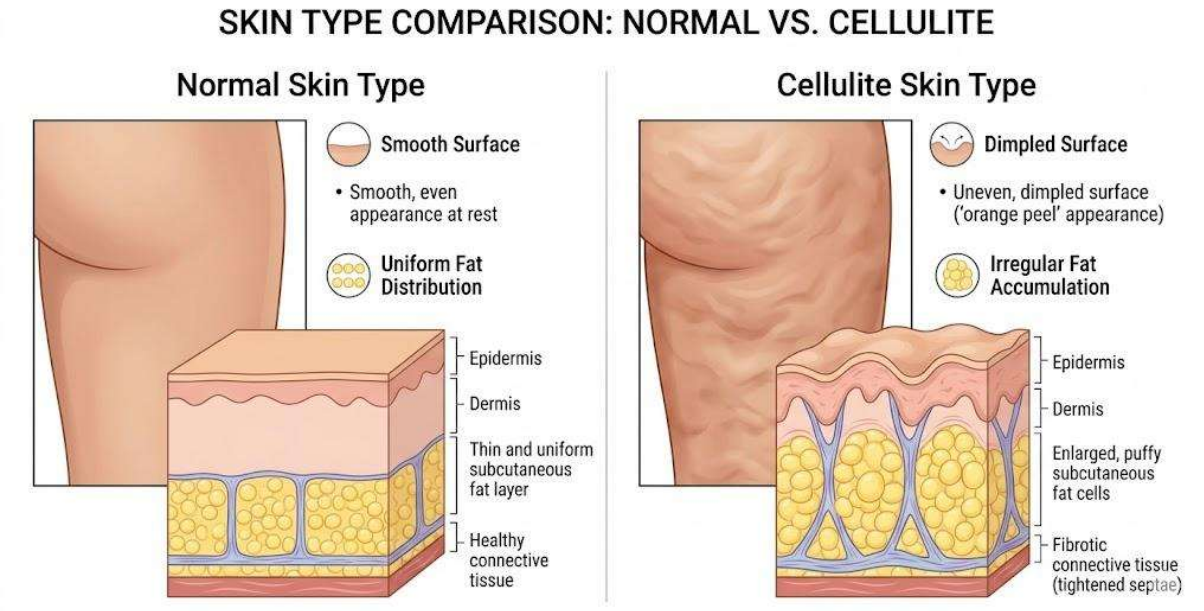


Figure 3. Skin type comparison

The onset of cellulite originates from micro-circulatory stasis (Hematic stasis). When blood circulation is impaired, adipocytes (fat cells) undergo physiological stress, leading to edema (swelling) and an increase in cellular volume. During this process, the ground substance of connective tissues and collagen fibers undergo degeneration, while the elastic fibers—responsible for skin elasticity—become fragmented. Simultaneously, abnormal hyperplasia (increase in number) and hypertrophy (increase in thickness) of reticular fibers occur, ultimately culminating in fibrous sclerosis, where the tissue becomes irreversibly hardened. Cellulite is a "multifactorial syndrome" resulting from a complex interplay of genetic predisposition, constitutional traits, hormonal imbalances, and vascular health. In particular, external factors such as poor dietary habits, stress, the use of high heels or restrictive clothing, postural imbalances, and metabolic disorders (including impaired hepatic or intestinal function) act as catalysts that further accelerate its progression. If left unaddressed, cellulite advances beyond a reversible state, following a chronic trajectory that deteriorates through progressive stages.

1.3.1 The 4 Stages of Cellulite Progression

Stage 1: The Edematous Phase

This is the earliest stage of cellulite, primarily driven by micro-circulatory stasis. The hallmark of this phase is edema (swelling), where interstitial fluid begins to accumulate between cells due to impaired blood and lymphatic flow. While the skin surface may still appear smooth to the naked eye, adipocytes (fat cells) are already beginning to enlarge, and metabolic waste products are starting to build up within the tissue. As this is a reversible stage where no permanent structural damage has occurred, full recovery is often achievable through interventions that improve circulation.

Stage 2: The Initial Fibrotic Phase

This stage serves as a critical turning point where structural changes in the skin tissue begin to manifest. Prolonged edema leads to hypoxia (oxygen deficiency) and the degeneration of the ground substance in the connective tissue. Consequently, the collagen and elastic fibers, which are responsible for skin firmness, begin to fragment. Although the skin may still look smooth at rest, the characteristic "peau d’orange" (orange-peel) effect becomes visible when the skin is pinched or compressed, signaling the weakening of the underlying support structure.

Stage 3: The Fibrotic Phase

In this stage, the formation of micronodules begins within the dermal layers. Enlarged clusters of adipocytes become encapsulated by thickened, hypertrophic reticular fibers, causing the tissue to harden significantly. At this point, dimpling and surface irregularities are clearly visible even in a standing position without any external pressure. The affected area may also exhibit a lower skin temperature compared to surrounding tissues due to severely compromised blood flow. This is considered a confirmed stage that is difficult to address through lifestyle changes alone.

Stage 4: The Sclerotic Phase

The final and most severe stage is characterized by fibrous sclerosis, where micronodules coalesce

into large, palpable macronodules. The drastic contraction of the connective tissue (septa) pulls down on the skin surface, resulting in deep depressions and a hardened, "mattress-like" texture. At this stage, the enlarged nodules often compress nerve endings, frequently causing pain upon palpation. Because the tissue damage is chronic and largely irreversible, professional medical intervention is essential to break down the hardened fibrous septa and forcefully stimulate circulatory recovery.

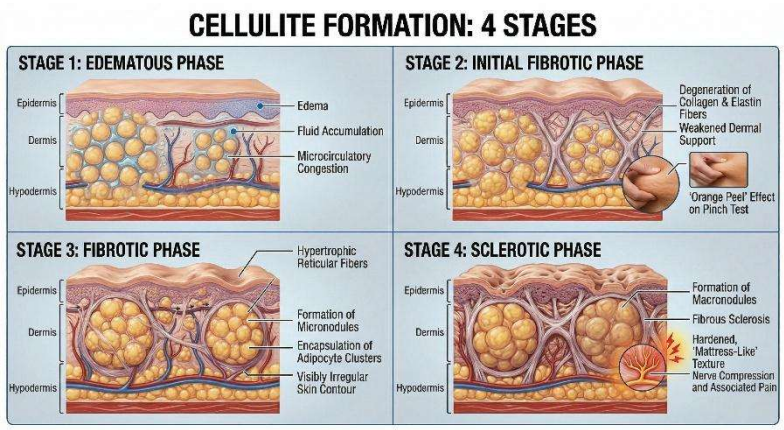


Figure 4. Cellulite formation

1.3.2 Clinical Classification: Three Primary Types of Cellulite

Cellulite is categorized into three distinct clinical types based on tissue density, anatomical location, and underlying etiology. Accurate identification of these types is essential for establishing an effective treatment protocol.

- Compact Cellulite (Solid / Dense Type)

This type is characterized by a highly dense and firm tissue texture upon palpation. It can be painful due to localized nerve compression, and the excessive expansion of the dermal layers may lead to the appearance of stretch marks (striae distensae) on the skin surface. Paradoxically, this type is most frequently observed in active individuals with excellent muscle tone and good physical conditioning. While it is the most prevalent form of cellulite, it typically demonstrates the highest clinical responsiveness and a favorable prognosis when targeted with appropriate energy-based treatments. It is commonly localized around the knees, outer thighs, and buttocks.

- Flaccid Cellulite (Soft / Loose Type)

Flaccid cellulite is predominantly seen in mature demographics or individuals who have experienced rapid weight fluctuations, resulting in diminished skin elasticity. Within the tissue matrix, sclerotic nodules have often already begun to form. This type is exacerbated by a sedentary lifestyle and is typically found in areas where the skin is thinner and more prone to sagging, such as the inner thighs and upper arms (brachium). Due to its lack of structural fixation, the tissue tends to move or "float" with body motion, making it a visually challenging type to correct.

- Edematous Cellulite (Congestive / Spongy Type)

This represents the most advanced pathological manifestation of cellulite progression, where the tissue appears swollen and takes on a spongy (cystic) consistency. Rather than simple adipose accumulation, this type is deeply rooted in severe fluid stagnation and systemic venous/lymphatic insufficiency. It is often highly sensitive, causing immediate pain upon palpation. It manifests extensively across the lower limbs (ankles and calves), pelvis, and the entire gluteal region. Successful management of this complex type requires a comprehensive approach that prioritizes the fundamental improvement of the circulatory system.

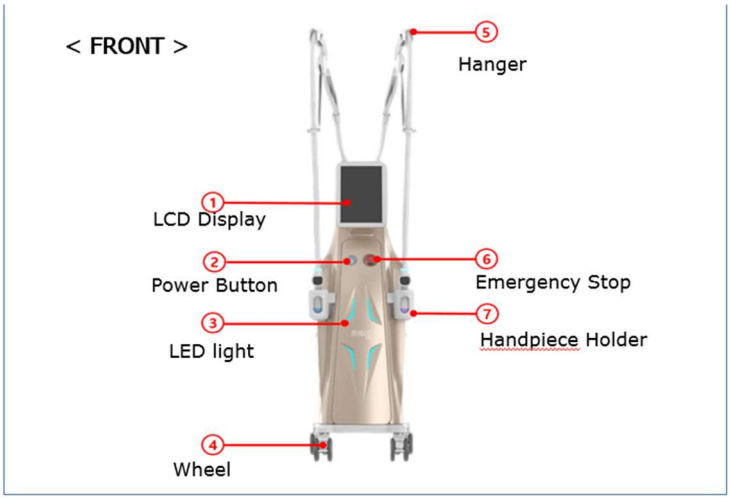
02

Operating Guidelines

Specification

Energy	Ultra High Frequency	
Frequency	2.45GHz	
POWER	Max. 200w	
Electrical Specifications	100~240Vac / 50~60Hz / 1500VA	
Dimensions	700(W) x 435(L) x 1090(H)	
Weight	63Kg	
Convenience System	Graphical User Interface (GUI)	
	12.1" Color Display Touch Screen	
	Smart Handpiece	- 3mm, 7mm, 12mm - LED indicator - 1.54" LCD screen - Four buttons • Energy Up / Down • Ready / Emission 

Components



① LCD Display : Monitor the current status of the device in real time.

② Power Button : The button to turn the device on and off.

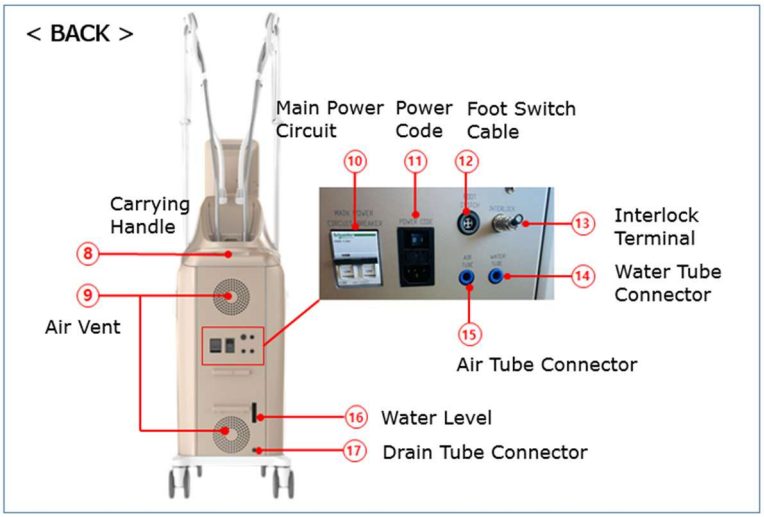
③ LED light : The operating status of the device.

④ Wheel : With a brake to secure the device and prevent movement during the procedure.

⑤ Hanger : Supports the cable connected to the handpiece.

⑥ Emergency Stop : Immediately shuts off all operations in the event of unexpected emergencies.

⑦ Handpiece Holder : Safely mount the handpiece before and after the procedure.



⑧ Carrying Handle : Handle for gripping when moving the device by pushing or pulling.

⑨ Air Vent : A passageway for discharging heat generated inside the device to the outside.

⑩ Main Power Circuit : Safety device that automatically lowers to protect the device in case of overcurrent.

⑪ Power Code : Connect the power cable.

⑫ Foot Switch Cable : Energy can be emitted by stepping on it.

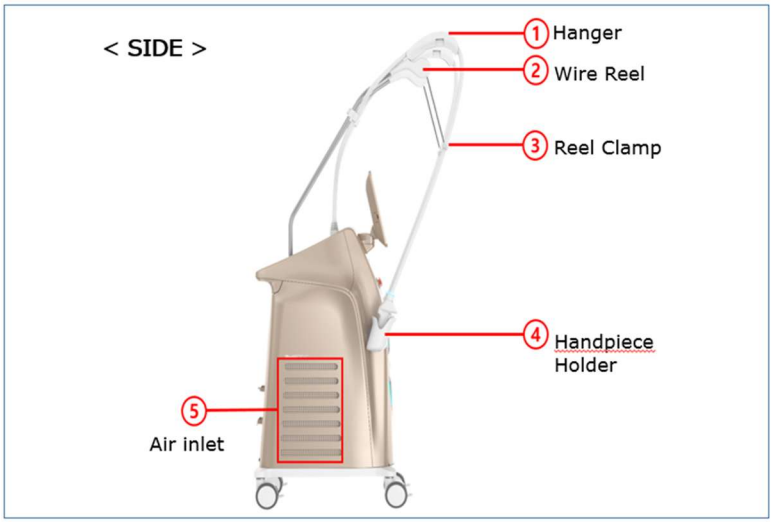
⑬ Interlock Terminal : Safety double lock.

⑭ Water Tube Connector : Connect the tube for coolant replenishment.

⑮ Air Tube Connector : Connect the air hose if air pressure is required.

⑯ Water Level : Visually check the amount of coolant inside the unit. Periodic checks are necessary because insufficient coolant can cause the unit to overheat.

⑰ Drain Tube Connector : A drain port connecting a tube to drain internal water when replacing coolant or storing the device for a long period.



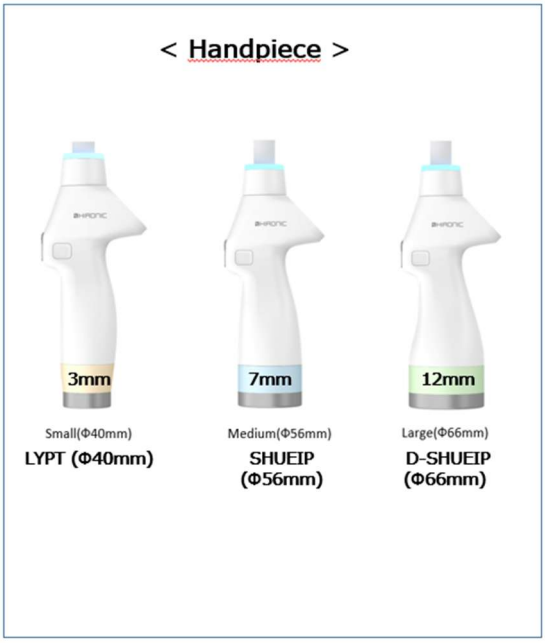
① Hanger : Supports the cable connected to the handpiece.

② Wire Reel : This is a device that adjusts the tension of the cable. When the operator pulls the handpiece, it releases smoothly, and when released, it pulls gently again, reducing wrist fatigue caused by the weight of the cable.

③ Reel Clamp : It serves to hold the cable in place so that it does not slip off the reel.

④ Handpiece Holder : Safely mount the handpiece before and after the procedure.

⑤ Air Inlet : Air intake and exhaust functions.

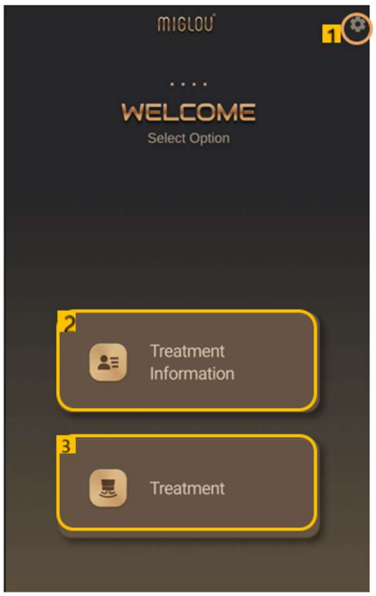


① HORN
②-1,3
: Dose -/+
②-2
: Shot on/off
②-4
: Standby/Ready

③ Information Display LCD
④,⑤ Cable
⑥ Water Hose
⑦,⑧ Main Body Connector

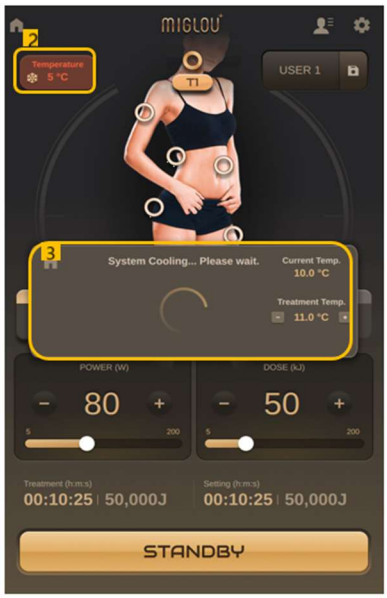
GUI

<HOME>



<Settings>

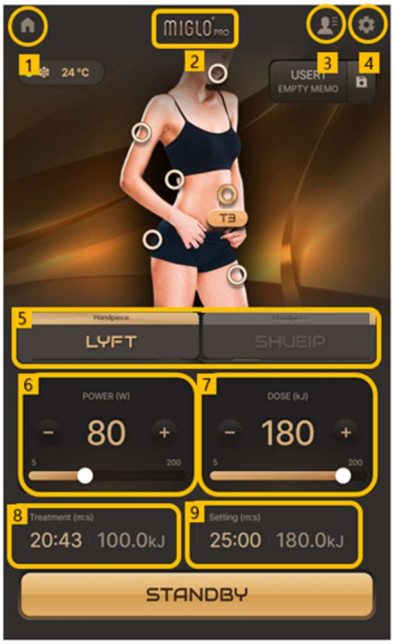
1) Settings
2) Treatment Information : Patient Procedure Recor
3) Treatment : HP selection for the procedure.



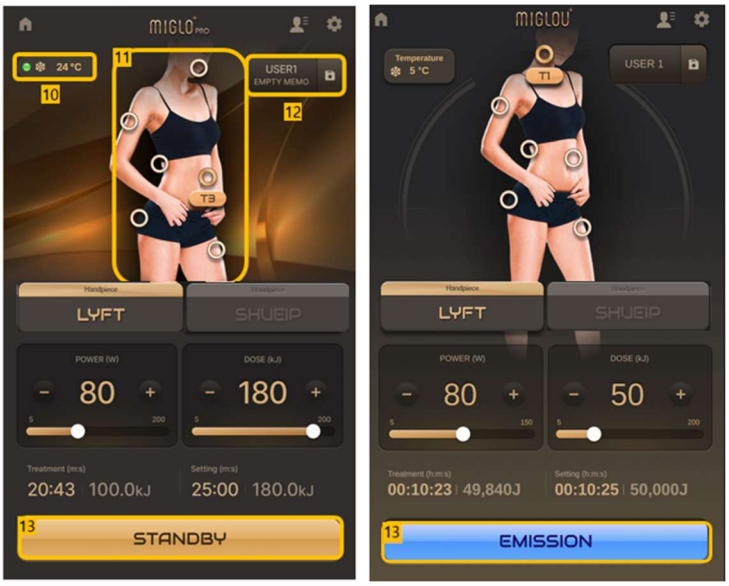
1) Press the <treatment> button to automatically switch to the temperature setting screen.

2) Set <Cooling Temperature>

3) Please wait until the set temperature is reached.



1) Go to Main Screen
2) Logo
3) Go to Treatment Information
4) Go to H/P Setting
5) Select H/P
: LYFT/SHUEIP
6) POWER (W) *Set in 10w increments
: Set Output Value
- LYFT: 10~100W
- SHUEIP : 10~200W
7) DOSE (kJ) *Set in 10kJ increments
: Select Total Energy Amount to Use
- LYFT: 10~100KJ
- SHUEIP : 10~200KJ
8) Treatment (m:s)
: Display Remaining Treatment Time and Remaining Energy Amount
9) Setting (m:s)
: Display Set Energy Amount and Time
* Time = Dose (kJ) Setting x 1000 / Power (w) Setting Value

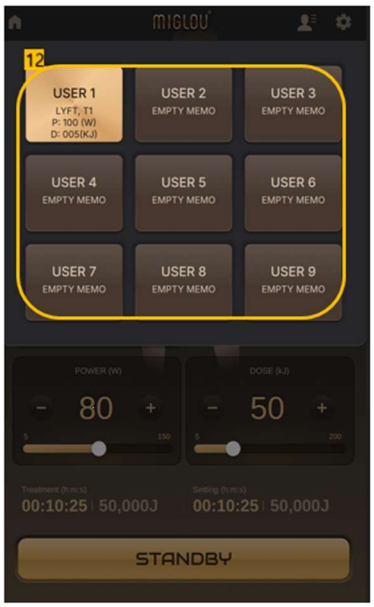


10) HP Surface Temperature

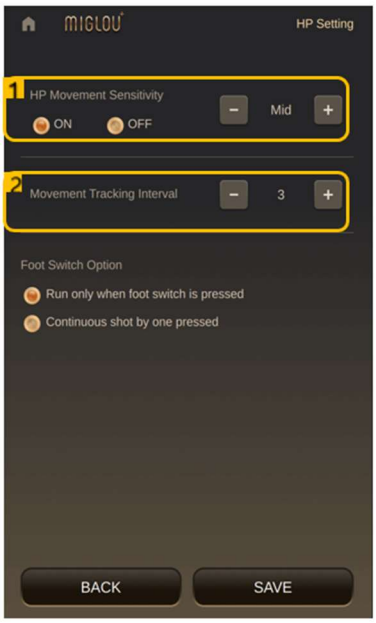
11) Treatment Part
: Select Treatment Area

12) Memory Mode
: Save Treatment Parameters

13) STANDBY
: Standby State Before Energy Irradiation
READY
: Ready for Energy Irradiation
Press Foot Switch or Hand Switch
To Irradiate Energy
EMISSION
: Energy Irradiation in Progress



12) Memory Mode
: Save Treatment Parameters



1) HP Movement Sensitivity :
Degree of sensitivity of handpiece movement.

2) Movement Tracking Interval :
Degree of how often handpiece movement is to be checked.

03

Clinical Procedure

1. Operational Guidelines

While this guide serves as a comprehensive operational resource for the system, it is not intended to supersede the independent clinical expertise or professional judgment of the practitioner. The foundational principle of every procedure must be the preservation of skin integrity. Treatments should be administered such that they do not impose excessive thermal or physical stress on the tissue. Selection of high-intensity power and energy levels requires rigorous caution and continuous monitoring to mitigate the risk of adverse effects or tissue damage.

Prior to configuring specific parameters, the operator must possess a thorough understanding of the physiological mechanisms and clinical objectives associated with each treatment modality.

The instructions provided herein constitute a recommended clinical framework rather than an exhaustive compendium for the system's utilization. Consequently, this manual should be viewed as a reference that must be integrated with the practitioner’s cumulative experience and real-time clinical observations of the patient’s response.

1.1 Clinical Indications & Purpose of Use

The **MIGLOU** system is a medical-grade platform engineered for the targeted deep thermal modulation of adipose tissue. It is primarily indicated for the pathological management of lipodystrophy and edematous fibrosclerotic panniculopathy (EFP), as well as for advanced body silhouette sculpting within dermatological and aesthetic surgical environments.

[Operator Requirements]

NOTE: Access to this device is strictly reserved for medical professionals who have attained clinical proficiency in relevant medical disciplines. Furthermore, comprehensive training and practical expertise in the specific treatment modalities offered by the **MIGLOU** system are mandatory to ensure patient safety and optimal results.

[Regulatory Compliance]

Operators assume full responsibility for verifying and maintaining compliance with all applicable laws and local healthcare regulations. It is the practitioner’s duty to ensure they possess the necessary

legal certifications and professional qualifications required to operate the system according to its designated clinical indications.

1.2 Pre-treatment Clinical Consultation and Assessment

To establish a highly customized treatment protocol, it is indispensable for the practitioner to perform a systematic physical evaluation and an in-depth medical history intake. The essential clinical data required for designing a precise, tailored treatment plan include:

i. Comprehensive Clinical History: Review of past medical history, underlying conditions, and current medications.
ii. Advanced Physical Evaluation: Detailed assessment of tissue density, elasticity, and cellulite grading through visual and tactile inspection.
iii. Assessment of Expectations: Identification of the patient's motivations and alignment on realistic clinical outcomes.

[Informed Consent and Patient Education]

The practitioner must provide thorough counseling regarding the treatment mechanism, projected outcomes based on individual physiological profiles, and the recommended number of sessions required to achieve optimal results. Furthermore, clear instructions for pre- and post-treatment care, along with a comprehensive overview of potential side effects, must be communicated to ensure patient compliance and safety.

1.2.1 Pre-treatment Clinical Consultation and Assessment

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iii. Assessment of Expectations: Identification of the patient's motivations and alignment on realistic clinical outcomes.

1.2.2 In-depth Physical Examination

To ensure the safety and precision of the **MIGLOU** protocol, a comprehensive analysis of the patient's general physical condition and target tissue structure is required.

[Key Assessment Parameters]

i. Morphotype & Symmetry: Identify gynoid/android types and assess overall body balance.

ii. Tissue & Circulation: Evaluate venous sufficiency, localized edema, cellulite grade, and skin laxity.
iii. Diagnostic Screening: Utilize ultrasound to identify potential lipomas, nodules, or pre-existing fibrous tissue.
iv. Clinical Safety: Conduct blood tests if necessary to rule out any medical contraindications.

[Suitability Criteria for **MIGLOU**]

i. Palpation Screening: Investigate any pain during touch, which may indicate advanced stages of cellulite.
ii. Adipose Layer Targeting: Optimal results are achieved when skinfold thickness is between 2 cm and 5.5 cm (a minimum subdermal fat layer of 1 cm is required).

1.2.3 Patient Motivations & Clinical Goals

Beyond assessing physical symptoms, it is essential to gather detailed insights into the patient's underlying motivations and desired outcomes.

i. **Needs Assessment:** Identify the specific aesthetic goals that led the patient to seek professional treatment.
ii. **Expectation Management:** Align the patient’s expectations with the realistic clinical potential of the **MIGLOU** protocol to ensure a high level of satisfaction and trust.

1.2.4 Clinical Contraindications & Safety Screening

Following the initial clinical assessment, the practitioner must evaluate the suitability of the **MIGLOU** protocol for the patient. For patient safety, a professional decision must be made to proceed with, postpone, or entirely exclude the treatment based on individual risk factors.

1.2.5 Absolute Clinical Exclusions

Under no circumstances should the **MIGLOU** treatment be administered to patients presenting with the following conditions. These contraindications are absolute and must be strictly observed.

i. Severe cardiac insufficiency or unstable cardiovascular disorders.

ii. Presence of active electronic implants, including pacemakers or defibrillators.
iii. Patients with implanted neurostimulators, such as Deep Brain Stimulation (DBS) devices.
iv. Advanced hepatic or renal failure/dysfunction.
v. Uncontrolled (decompensated) Diabetes Mellitus (Type I and II).
vi. Organ transplant recipients.
vii. Acute vascular disorders, including active phlebitis, thrombophlebitis, or venous thrombosis.
viii. Coagulopathy or identified hemorrhagic diathesis.
ix. Active neoplasia or a history of malignancy within the past 60 months (5 years).
x. Acute infectious diseases, with specific emphasis on viral hepatitis (Type B and C).
xi. Pregnancy, postpartum period, and lactation (up to 10 months post-delivery).
xii. Clinically recognized hypersensitivity to the treatment modalities of the device.

1.2.6 Relative Contraindications & Clinical Precautions

The following conditions require professional discretion and meticulous assessment. The practitioner must evaluate the severity and anatomical location to determine whether to proceed with or postpone the **MIGLOU** protocol.

i. Presence of skin pathologies, telangiectasias, lipomas, or fibrotic tissue in the target area.
ii. Heat-sensitive disorders (e.g., recurrent Herpes Simplex).
iii. Predisposition to keloid formation or impaired wound healing.
iv. Medication: Recent use of retinoids (within 1 month), steroids/NSAIDs (within 1 week), or anticoagulants (risk of persistent erythema).
v. Metabolism: Managed diabetes, blood pressure fluctuations, and hyperlipidemia (cholesterol/triglycerides).
vi. History of autoimmune diseases, phlebitis, thrombosis, or malignancy (> 5 years ago).
vii. Menstruation, minors, or breastfeeding (after 10 months postpartum).
viii. Body Composition: Optimized for localized adiposity (BMI ≤ 30) rather than systemic obesity management.
ix. Expectation Management: Caution is advised for patients with unrealistic clinical expectations.

1.2.7 Relative Contraindications & Clinical Precautions

Clinical Exclusion Zones & Anatomic Restrictions To ensure therapeutic safety and optimal energy distribution, the following areas and conditions are strictly excluded from the **MIGLOU** treatment scope.

i. Prohibited Areas: Head, neck, mammary/decolleté regions, genitalia, and mucous membranes.

ii. Structural Risks: Bone protrusions, major lymph node stations, and pathways of major vessels (femoral, subclavian, and brachial arteries/veins).
iii. Thickness Threshold: Areas with a subdermal fat layer less than 1 cm.
iv. Synthetic Objects: Permanent implants (metallic/plastic plates, screws, prostheses), injected substances (chemical/autologous), and body piercings.
v. Surface Factors: Tattoos, permanent makeup, open wounds, and acute inflammatory sites (rashes, infections, hematomas).
vi. Tissue Pathologies: Fractures (even during recovery), hernias, lipomas, severe fibrosis, or extreme tissue laxity.
vii. Sensory/Circulatory Impairment: Ischemic tissues (risk of necrosis) and areas with absent or diminished sensitivity.
viii. Feedback Compromise: Pharmacologically anesthetized areas where the patient's pain-feedback loop is impaired.
ix. Surgical History: Spinal areas previously subjected to procedures such as laminectomy.

2. Treatment Procedure

2.1 Pre-treatment Precautions

i. Screen for contraindications: pregnancy, pacemaker, internal metal implants, or severe systemic conditions
ii. Check for the presence of metal, implants, or fillers in the treatment area
iii. Do not treat areas with active inflammation, infection, burns, or dermatologic conditions
iv. Use caution in areas with impaired sensation due to increased burn risk
v. Assess vascular prominence and proximity to lymphatic regions
vi. Evaluate skin thickness and fat layer to determine appropriate handpiece selection

2.1.1 Guidelines for Enhancing Energy Delivery

i. Moisturizer Suspension: Due to the high affinity of microwaves for water molecules, patients must cease the application of topical moisturizers one week prior to the session. This minimizes energy attenuation in the superficial layers and maximizes thermal penetration into the adipose tissue.
ii. Hydration Strategy: To facilitate efficient metabolic drainage of interstitial fluids, a daily intake of 2 liters of water is mandatory, starting 24 hours before the procedure.

2.1.2 Standardized Clinical Documentation

For objective monitoring of treatment efficacy, consistently reproduce photographic records using standardized lighting, patient positioning, and biometric reference markers.

2.1.3 Immediate Pre-Procedural Steps

i. Surface Cleansing: Thoroughly remove all impurities (lotions, oils, etc.) that may interfere with energy delivery or sensor accuracy. Ensure the skin is completely dry after rinsing.
ii. Hair Removal: Shave dense hair in the target area to optimize the interface between the handpiece and the skin.
iii. Grid Marking: Demarcate the treatment area into 15x15 cm sub-sections for systematic energy distribution.
iv. Thickness Assessment: Measure the skinfold thickness within each grid while the patient is standing to determine precise parameters.
v. Strategic Positioning: For abdominal contouring, position the patient with the torso slightly flexed to isolate the adipose layer from the underlying muscle.
vi. Coupling Medium: Apply a minimal film of medical-grade vaseline oil to ensure fluid movement of the handpiece. Avoid excessive application to maintain sensor integrity.

2.2 Treatment Precautions

Step-by-Step Operational Sequence

[System Initialization & Energy Strategy]

i. Parameter Selection: Based on the clinical assessment, select the most effective protocol from the **MIGLOU** internal database or configure manual settings.
ii. Thermal Modulation: Adopt a conservative approach by initiating treatment at lower power levels. The primary objective is to achieve homogeneous subcutaneous hyperthermia through gradual heating, rather than rapid thermal spikes. This ensures superior control over the tissue response and minimizes potential adverse effects.

[Epidermal Protection & Cooling]

i. Active Cooling: Maintain the skin cooling interface at 5°C. This integrated cooling mechanism safeguards the epidermis and dermis against thermal stress while optimizing energy penetration into the deeper adipose layers and facilitating interstitial drainage.

[Handpiece Dynamics & Technique]

i. Orthogonal Application: The handpiece must be held strictly perpendicular to the skin surface. Utilize the intuitive LED guidance system to ensure constant and stable coupling throughout the procedure.
ii. Dynamic Motion: Perform smooth, continuous circular or linear strokes. Static application is strictly prohibited to prevent localized overheating.
iii. Dosing Guidelines: For a standard 15x15 cm sub-area, the recommended duration is 7 to 10 minutes. For smaller anatomical regions, power and dose parameters should be reduced proportionally to maintain appropriate energy density.

[Automated Safety Interruption]

i. The system intelligently calculates the treatment duration based on the pre-set dose. Upon reaching the target value, energy delivery automatically ceases. To proceed to the subsequent treatment zone, the operator must re-engage the dose selection interface.

2.3 Treatment Cycle

Treatment is typically performed over multiple sessions scheduled at regular intervals. A commonly used protocol involves approximately four sessions, each spaced about Three ~ Four weeks apart.

To support treatment outcomes and promote tissue recovery, adjunctive care such as lymphatic drainage may be considered between sessions and following completion of the treatment cycle.

2.4 Post-treatment

i. Measures to support lymphatic circulation may be considered following the procedure to aid recovery.
ii. Retreatment of the same area should be performed after an appropriate interval, generally around 3–4 weeks.
iii. Patients are advised to avoid direct sun exposure for approximately 48 hours after treatment.
iv. Mild erythema may occur in the treated area; exposure to hot water or other potential irritants should be avoided until symptoms have resolved.
v. Maintaining a balanced diet and engaging in moderate physical activity may help support overall treatment outcomes.

04

protocol

[FACE]

Category	Face (3mm)	Face (7mm)
Power	80W - 110W	90W - 120W
Energy	60,000J - 80,000J	60,000J - 80,000J
Time	12:00 - 13:00	11:00 - 12:00

[BODY]

Category	Body (7mm)				
Area	Arms	Thighs	Trochanter	Back	Abdomen & Flanks
Power	90W - 120W	100W - 130W	100W - 130W	100W - 130W	110W - 130W
Energy	50,000J - 60,000J	50,000J - 70,000J	50,000J - 70,000J	50,000J - 70,000J	90,000-140,000J
Time	8:00 - 10:00	8:00 - 9:00	8:00 - 9:00	8:00 - 9:00	13:00 - 18:00

Category	Body (12mm)				
Area	Arms	Thighs	Trochanter	Back	Abdomen & Flanks
Power	110W - 140W	120W - 140W	120W - 140W	120W - 140W	110W - 150W
Energy	60,000J - 80,000J	70,000J - 100,000J	60,000J - 100,000J	60,000J - 190,000J	140,000-180,000J
Time	9:00 - 10:00	9:00 - 12:00	8:00 - 12:00	8:00 - 12:00	16:00 - 20:00

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