

FAQ

Frequently Asked Questions

SYNER
JET^{PRO}



Disclaimer

The applications described in the FAQ (Frequently Asked Questions) in this guide are based on various clinical studies, academic literature, and a range of case experiences.

Treatment parameters must be adjusted according to individual patient conditions.

The manufacturer shall not be held responsible for any issues arising from improper use of the equipment or excessive treatment.

Prior to use, practitioners must review the user manual and fully understand the correct operation and handling of the device before performing any procedures.

The treatment protocol includes pre-treatment consultation (such as patient history assessment and lesion diagnosis), treatment procedures, number of sessions, expected outcomes, potential side effects, precautions for both practitioners and patients before and after treatment, informed consent, selection of appropriate treatment parameters, post-treatment care, medication prescriptions, and follow-up scheduling.

The indications and parameters provided in this booklet may be updated based on clinical experience and accumulated case data. Practitioners are advised to refer to the latest clinical updates when applying treatments.



Q1. What are SynerJet Pro's core clinical advantages, and how does it perform as a standalone vs. combination therapy?

The SynerJet Pro distinguishes itself in the aesthetic landscape by moving beyond standard pneumatic delivery. It is a third-generation hybrid platform that integrates three distinct modalities: **Microjetting, Electroporation (EP), and Cold Plasma.**

- **"Fluid Subcision" Mechanism:** The high-pressure kinetic energy forcefully shears horizontal fibrotic bands in rolling and boxcar scars without the trauma, friction, or sheer stress associated with rigid needles.
 - **Precision and Reproducibility:** Unlike manual injections, the electronic control system standardizes depth, pressure, and volume across the entire treatment area, eliminating operator fatigue and variability.
- As a standalone device, the SynerJet Pro excels in rapid, non-invasive skin conditioning and global rejuvenation. It is highly effective for superficial hydration, brightening, mild atrophic scarring, and generalized skin laxity. It mechanically loosens mild fibrotic structures while evenly distributing non-crosslinked hyaluronic acid, polynucleotides, or peptides.

Combination Therapy Efficacy (The Multimodal Approach)

For the dual-action treatment of both enlarged pores and atrophic scars, **Radiofrequency (RF) Microneedling** stands out as the premier energy-based device to integrate with the SynerJet Pro.

Pores and scars require both structural contraction and volumetric support.

- **The Thermal & Mechanical Phase:** RF Microneedling creates physical micro-channels and delivers controlled thermal coagulation deep into the reticular dermis. This thermal injury is crucial because it physically contracts the lax collagen walls surrounding enlarged pores and stimulates matrix metalloproteinases (MMPs) to break down the rigid, fibrotic borders of atrophic scars.
- **The Kinetic & Regenerative Phase:** RFMN cannot add volume or hydration. This is where the SynerJet Pro bridges the gap. By following the thermal treatment with the SynerJet Pro, you can forcefully deliver a biostimulator like **Poly-D,L-Lactic Acid (PDLLA)**. The device's microjetting provides a "fluid subcision" effect to further release tethered rolling scars, while the electroporation drives the active ingredients deep into the highly metabolically active tissue.



Q2. How effective is the device for various scar types (acne, ice pick, keloids, burns), and what specific precautions are needed?

Atrophic Acne Scars (Rolling & Boxcar) – very effective

The high-velocity pneumatic stream generates a powerful lateral kinetic force within the mid-to-deep dermis. This acts as a "3D fluid subcision," effectively shearing and releasing the horizontal fibrotic bands that pull the skin downward

icepick Scars-: Low (As a standalone)

Icepick scars are narrow, deep, vertically oriented epithelial tracts extending into the deep dermis or subcutis. Because they are not held down by horizontal anchoring bands, the lateral shearing force of a fluid subcision does not address the structural defect. The epithelialized walls must be physically or chemically destroyed to allow the tissue to fill from the bottom up.

Keloid and Hypertrophic Scars – very effective

Traditional needle infiltration into the dense, unyielding extracellular matrix of a keloid requires immense manual pressure, and the mechanical friction of the needle itself can trigger secondary fibroblastic proliferation. Pneumatic delivery bypasses this by forcing therapeutic agents (such as intralesional Triamcinolone Acetonide or 5-Fluorouracil) evenly throughout the dense core via micro-droplets. This achieves superior drug bioavailability and a more uniform clinical response without the localized pooling common with needles.

Burn Scars-: effective

- Burn scars present a chaotic landscape of rigid contractures alongside fragile, atrophic areas. The kinetic energy of the microjet provides mechanical micro-fragmentation of the rigid collagen bundles, significantly improving tissue compliance, elasticity, and range of motion. Depositing deep hydrating elements or regenerative complexes into these zones helps normalize tissue architecture.

To maintain an impeccable safety profile when implementing these advanced scar protocols, several precise technical parameters must be managed:

- keloid matrices require higher initial pressure thresholds to achieve adequate core penetration. Conversely, burn scars display highly variable tensile strength within the same lesion. The operator must dynamically adjust the pressure settings to avoid epidermal "blow-outs" or excessive mechanical trauma in thinner, compromised areas of burn tissue
- Because pneumatic microjetting and electroporation dramatically enhance the tissue's absorption capacity and uniform distribution of active compounds, standard drug concentrations must be re-evaluated. When delivering corticosteroids into keloids, for example, titrate the concentration slightly downward to minimize the risk of surrounding dermal atrophy, hypopigmentation, or telangiectasia.
- While controlled kinetic trauma stimulates healthy remodeling, excessive kinetic force in a highly active, hyper-vascular keloid can inadvertently exacerbate the lesion.
- Burn scars frequently suffer from permanently compromised microvasculature and a weakened epidermal barrier. Creating high-pressure micro-channels demands meticulous sterile technique and a carefully tailored post-care regimen to avoid delayed wound healing or secondary infection



Q3. What are the most common mistakes that hinder optimal results in scar treatments?

highlighting these common pitfalls provides immediate, high-yield clinical value.

1. The most frequent error is attempting to treat a polymorphic scar field with a single modality. Acne scars rarely present uniformly.

- **The Mistake:** Relying solely on an energy-based device (EBD) like RF Microneedling to treat deep icepick scars, or using pneumatic kinetic delivery (fluid subcision) expecting it to resolve vertical epithelial tracts.
- **The Correction:** Structuring a targeted, multimodal protocol. Icepick scars require focal destruction (TCA CROSS or excision) first

2. When introducing biostimulators into a highly traumatized or fibrotic dermal matrix, the physical architecture of the polymer dictates the clinical outcome and the safety profile.

- **The Mistake:** Failing to strictly distinguish between Poly-D,L-Lactic Acid (PDLLA) and Poly-L-Lactic Acid (PLLA) in treatment planning. Utilizing the heavy, solid crystals of PLLA for superficial scar filling or high-pressure pneumatic delivery significantly increases the risk of uneven dispersion, agglomeration, and subsequent nodule formation.
- **The Correction:** Prioritizing PDLLA for scar revision, particularly when combined with pneumatic devices. The spongy, porous microsphere structure of PDLLA integrates far more predictably under pneumatic pressure, providing safe, uniform volumetric scaffolding and a smoother neocollagenesis cascade.

3. Improper Sequencing of Thermal and Kinetic Trauma

Combining RF Microneedling or Fractional devices with kinetic delivery and regenerative agents is the gold standard for contouring and skin quality, but incorrect timing compounds inflammation and destroys active ingredients.

The Mistake: Delivering heat-sensitive biologicals (like exosomes or delicate peptides) and immediately following up with aggressive thermal RF passes in the exact same tissue depth, which denatures the proteins. Another common error is delivering high-pressure pneumatic kinetic streams into tissue that has just been heavily sheared and coagulated by RFMN, leading to epidermal blowout and unpredictable product pooling.

The Correction: If performing a same-day protocol, heat-sensitive compounds must be delivered pneumatically before thermal EBDs, or placed in different dermal planes. Ideally, staging the treatments 2 to 4 weeks apart allows the physician to capitalize on the fibroblast-rich environment created by the initial thermal wound-healing response.

4. Overlooking the Inflammatory and Vascular Thresholds

Atrophic and hypertrophic scars both possess complex vascular underpinnings that dictate how they heal.

The Mistake: Aggressively treating scars characterized by intense post-inflammatory erythema (PIE) or highly active vascular keloids with high-energy mechanical or thermal trauma without first stabilizing the tissue. This often leads to prolonged downtime, hyperpigmentation, or scar rebound.

The Correction: Modulating the vascular component first—often utilizing targeted vascular lasers or intense pulsed light—to lower the inflammatory threshold of the tissue before introducing aggressive kinetic subcision or thermal coagulation.



Q4. How do pressure settings correlate with penetration depth and target layers across different facial areas?

Mastering pneumatic jet injection requires a paradigm shift from visual depth (seeing a needle penetrate) to calculated kinetic depth. In devices like the SynerJet Pro, penetration is not solely dictated by the machine's pressure setting; it is a dynamic equation of Kinetic Pressure + Fluid Volume + Tissue Compliance (Density and Thickness).

Because facial skin thickness varies drastically—from 0.5 mm in the periorbital region to over 2.5 mm on the mid-cheek—a static pressure setting will deposit the product into entirely different histological layers depending on the anatomical zone.

Low Pressure / Low Volume Settings

- Target Layer: Epidermis to Papillary Dermis (Superficial).
- Clinical Goal: Barrier repair, deep hydration, and superficial brightening. Delivery of heat-sensitive exosomes, peptides, and non-crosslinked hyaluronic acid.
- Dispersion Pattern: A broad, shallow, umbrella-like lateral spread just beneath the dermal-epidermal junction.

High Pressure / High Volume Settings

- Target Layer: Deep Dermis to Subdermal Junction.
- Clinical Goal: High-impact kinetic fluid subcision for tethered rolling scars, deep volumetric lifting, and hypertrophic/keloid core penetration.
- Dispersion Pattern: An aggressive, downward-driving force that forcibly shears horizontal fibrotic bands before spreading laterally above the superficial muscular aponeurotic system (SMAS).



Q5. Why is a 33-degree angle considered optimal for subcision using Synerjet Pro?

1. Atrophic rolling scars and bound-down tissue are tethered by horizontal fibrotic bands in the mid-to-deep dermis. To release these tethers, the kinetic energy must travel laterally. By lowering the treatment trajectory to 33 degrees, the high-velocity fluid stream enters the skin tangentially. This creates a powerful, horizontal wedge of fluid that travels parallel to the dermal planes, efficiently shearing and snapping the restrictive fibrotic bands.

2. Precise Confinement to the Reticular Dermis

The 33-degree entry mathematically optimizes the depth of the kinetic shockwave. It confines the sheer force and the delivered fluid strictly to the reticular dermal plane—the exact anatomical depth where scar tethering occurs. A steeper angle risks driving the fluid pressure down into the subcutaneous fat layer, bypassing the fibrotic bands entirely and wasting the regenerative product.

3. Minimizing Unwanted Deep Tissue Dissection

While effective subcision relies on controlled mechanical trauma, driving high-pressure fluid at steeper angles can cause unpredictable deep vertical dissection and heighten the inflammatory response. The acute 33-degree angle directs the primary force laterally. This ensures the procedure mitigates unnecessary vertical trauma, gently opening a uniform, horizontal dermal pocket perfectly primed for the uniform deposition of biostimulators.



Q6. Which materials yield the best scar remodeling results, and how is product loss minimized during application?

Here are the optimal materials for scar remodeling and the technical parameters required to minimize product loss during application.

Optimal Materials for Scar Remodeling

1. Volumetric Scaffolding: Poly-D,L-Lactic Acid (PDLLA)

For atrophic acne scars (rolling and boxcar) and general dermal structural deficits, PDLLA is the premier biostimulator for pneumatic delivery.

- The Clinical Distinction: It is critical to distinguish PDLLA from standard Poly-L-Lactic Acid (PLLA) in these protocols. PLLA consists of solid, heavy crystals that carry a high risk of agglomeration, uneven dispersion, and nodule formation when forced through a high-pressure pneumatic nozzle. In contrast, PDLLA features a spongy, porous microsphere architecture. This allows it to compress and disperse fluidly through the microjetting process, integrating seamlessly into the reticular dermis to provide uniform volumetric scaffolding and a smooth neocollagenesis cascade.

2. Regenerative Modulation: Polynucleotides (PN) and Exosomes

For managing post-inflammatory erythema (PIE), accelerating barrier recovery, and improving global tissue quality over scarred areas, PN and exosomes are highly effective.

- The Clinical Rationale: These biologicals excel at reducing the prolonged inflammatory phase associated with severe scarring. Because they are highly sensitive to heat and mechanical degradation, delivering them pneumatically (especially in a staged protocol prior to thermal EBDs) ensures their structural integrity remains intact while maximizing intracellular bioavailability via electroporation.

3. Fibrotic Down-Regulation: Intralesional Corticosteroids

For hypertrophic and keloid scars, standard Triamcinolone Acetonide (often blended with 5-Fluorouracil) remains the gold standard, but kinetic delivery transforms its efficacy.

- The Clinical Rationale: Pneumatic delivery forces the solution into a micro-droplet mist, saturating the dense fibrotic core far more uniformly than a rigid needle. This enhanced bioavailability means you can achieve superior flattening of the scar while often titrating the concentration down, mitigating the risk of surrounding dermal atrophy.

Mitigating Product Loss During Application

Product loss during pneumatic injection typically manifests as "splash-back" or trans-epidermal leakage.

Pneumatic devices are highly sensitive to fluid rheology.

- If a product is too viscous, it will fail to clear the micro-nozzle efficiently, causing pressure build-up and surface pooling.
- When utilizing PDLLA, ensure it is rigorously reconstituted and adequately hydrated according to protocol so the microspheres are suspended uniformly. Using uncrosslinked hyaluronic acid as a carrier fluid can optimize the viscosity, allowing the kinetic stream to glide through the epidermal barrier without ricocheting.

The most common cause of product loss is a compromised seal between the nozzle and the epidermis, allowing pressure to escape laterally before penetrating the skin.



- The "Trampoline" Technique: To maintain this seal on highly contoured or lax areas (like the perioral region or lateral cheeks), apply firm counter-traction to the surrounding skin. Creating a taut surface ensures the kinetic shockwave drives strictly downward and laterally into the dermis, rather than bouncing off a yielding surface.

4. Surface Energy Modification (Cold Plasma)

If your platform includes a Cold Plasma modality (like the SynerJet Pro), it should always be utilized prior to microjetting. Cold plasma dramatically alters the skin's surface energy, rendering the epidermis highly hydrophilic. This temporary reduction in surface tension acts as a magnet for the kinetic fluid stream, significantly reducing surface pooling and drawing the product deeper into the transient micro-channels.

5. Dynamic Volume Calibration

Attempting to push too much fluid per shot into areas with minimal dermal thickness (like the forehead or periorbital zones) guarantees product loss, as the tissue physically cannot accommodate the volume. Lowering the volume setting per shot while increasing the density of your passes ensures 100% of the material is retained within the dermal matrix.

Q7. What are the optimal dilution settings for PLLA/PDLLA to prevent complications like nodules or granulomas?

PDLLA features a spongy, porous microsphere architecture.

Standard Dilution (50mg vial): 10 cc of normal saline

200 mg vial: 15 cc of normal saline

PLLA consists of solid, heavy, and irregularly shaped crystals

Insufficient dilution or inadequate hydration time guarantees that these solid particles will aggregate, leading to a high risk of late-onset nodules. PLLA is generally contraindicated for superficial dermal placement and is not the ideal candidate for high-pressure pneumatic delivery.

- Standard Dilution (150mg vial): 15 cc SWFI



Q8. What is the optimal treatment sequence and protocol design when combining Synerjet Pro with RF microneedling or fractional lasers?

Combining a non-needle pneumatic jet injector with Radiofrequency (RF) microneedling or fractional devices creates a highly effective multimodal protocol. This approach leverages two distinct pathways for tissue remodeling: kinetic energy for uniform dermal dispersion of actives, and controlled thermal/mechanical damage for structural tightening.

Because both modalities stimulate the wound-healing cascade, clinical success relies on strategic sequencing to maximize neocollagenesis while preventing compounded inflammation and shear stress on the tissue

1. The Staged Protocol (Recommended for Optimal Safety and Synergy)

Spacing the modalities 2 to 4 weeks apart is the safest way to respect tissue tolerance and capitalize on the prolonged wound-healing phases.

- **Session 1:** Thermal & Mechanical Remodeling. Begin with RF Microneedling or a Fractional device. This initiates the inflammatory phase, stimulates matrix metalloproteinases (MMPs), and triggers the structural contraction of the dermal matrix.

- **Session 2 (14–28 days later):** Kinetic Delivery & Biostimulation. At this stage, the tissue is metabolically hyperactive and rich in fibroblasts. Utilizing a non-needle jet injector to deliver regenerative agents (such as exosomes, skin boosters, or biostimulators) accelerates tissue recovery, addresses post-inflammatory erythema (PIE), and bathes the newly forming collagen in a highly hydrated environment.

2. The Same-Day Protocol (Advanced Clinical Management)

If a combined session is necessary for patient convenience, the order of operations and targeted depths are critical. Delivering a high-pressure kinetic jet into tissue that has just been mechanically and thermally compromised by RFMN can cause excessive shear trauma to the epidermal barrier and unpredictable product dispersion.

- **Sequence:** Perform the **non-needle jet injection first**. This allows you to deposit the active solution uniformly into the intact mid-to-deep dermis using pneumatic energy.

- **Follow-up:** Proceed with the **RF Microneedling**. Adjust the needle depth and energy to target the superficial-to-mid dermis (creating tightening and micro-channels) without overlapping the exact kinetic trauma zones of the jet injector.

- **Post-Care:** Apply topical soothing agents or a sterile biocellulose mask, as the skin will be highly sensitized. Avoid any further aggressive topical rubbing.



Q9. What are the expected pain levels, required anesthesia, and typical downtime (bruising/swelling) post-treatment?

- **Pain Profile:** Mild. Patients typically describe the microjetting as a rapid "flicking" or snapping rubber band sensation. The electroporation and cold plasma phases are generally painless, producing only a mild, transient tingling.

- **Anesthesia:** Standard topical anesthetic (e.g., Lidocaine 2.5% / Prilocaine 2.5%) applied for 20 to 30 minutes is more than sufficient.

expected Downtime: Bruising and Swelling

- **Immediate Post-Treatment:** The hallmark of high-pressure pneumatic delivery is the immediate formation of localized papules or ischemic "wheals" at the entry sites, accompanied by mild erythema. This is entirely normal and indicates successful volumetric fluid placement in the dermis.

- **Resolution:** These fluid wheals typically subside rapidly as the carrier fluid is absorbed, usually within 1 to 3 hours.

- **Bruising Risk:** Very low. Because the kinetic stream bypasses the friction of a rigid needle, vascular disruption is minimal. Minor petechiae or a pinpoint bruise may occasionally occur if a superficial vessel is directly struck, but global bruising is exceptionally rare.

To mitigate the compounded edema from multimodal sessions, strictly advise patients against aggressive icing, non-steroidal anti-inflammatory drugs (NSAIDs), or harsh active topicals (like retinoids or strong AHAs) for the first 72 hours. The goal is to modulate, not suppress, the carefully orchestrated inflammatory cascade that drives structural tissue tightening and neocollagenesis.



Q10. What are common complications and user mistakes, and what steps should be taken to prevent them?

The most severe complications in kinetic delivery stem from misunderstanding polymer architecture.

- **The Mistake:** Utilizing standard Poly-L-Lactic Acid (PLLA) for pneumatic delivery or superficial contouring. The solid, heavy crystal structure of PLLA is prone to agglomeration under high pneumatic pressure, leading to nozzle clogging, uneven mid-dermal deposition, and a high risk of late-onset nodules or true immune-mediated granulomas.

- **The Prevention:** Strictly differentiate polymers in your treatment planning. For pneumatic subcision and superficial structural contouring, exclusively utilize Poly-D,L-Lactic Acid (PDLLA)

Anatomical Miscalibration: The Epidermal "Blow-Out"

Pneumatic delivery requires dynamic spatial awareness. Treating the face with a static pressure setting ignores the drastic variations in dermal thickness.

- **The Mistake:** Applying high-pressure and high-volume settings to thin-skinned anatomical zones (like the periorbital region or the forehead). This causes the kinetic stream to strike the underlying bone or muscle fascia and ricochet outward, resulting in an epidermal "blow-out" (trans-epidermal product leakage), localized hematomas, or severe, uncomfortable mechanical edema.

- **The Prevention:** Master dynamic pressure calibration. High pressure is reserved strictly for thick dermal areas (mid-cheek, zygomatic arch) to release fibrotic anchors. When moving to the forehead or periorbital zones, immediately dial down the pressure and volume per shot to ensure the kinetic shockwave is fully absorbed by the delicate tissue.

3. Synergistic Sequencing Errors: Compounded PIE

Combining kinetic delivery with RF Microneedling is the pinnacle of multimodal contouring, but stacking trauma without respecting tissue biology invites severe inflammatory complications.

- **The Mistake:** Executing a same-day protocol where heat-sensitive biologicals (exosomes, peptides) are pneumatically delivered after the RFMN passes, where the residual thermal zones denature the proteins. Alternatively, aggressively stacking both modalities on a patient with active, hyper-vascular scarring, leading to prolonged post-inflammatory erythema (PIE) and barrier breakdown.

- **The Prevention:** Sequence based on mechanism. If treating same-day, heat-sensitive actives must be delivered before thermal EBDs. However, the safest and most effective method for true structural contouring is the Staged Protocol. Spacing the thermal RFMN session 2 to 4 weeks prior to the PDLLA kinetic delivery respects the tissue's inflammatory threshold and places the biostimulator into a perfectly primed, fibroblast-rich environment.

4. Angle and Depth Misjudgments: Unwanted Deep Dissection

The geometry of the handpiece dictates the specific layer of tissue traumatized by the kinetic stream.

- **The Mistake:** Attempting to perform fluid subcision for tethered rolling scars using a perpendicular (90-degree) angle. This drives the high-pressure fluid deep into the subcutaneous fat layer or the SMAS, bypassing the dermal fibrotic tethers entirely, wasting the product, and risking deep structural inflammation without surface benefit.



- **The Prevention:** Maintain a strict 33-degree angle for all subcision passes. This tangential entry confines the kinetic shockwave strictly to the reticular dermis, maximizing the horizontal shearing force necessary to snap fibrotic bands while keeping the biostimulator in the correct anatomical plane for optimal neocollagenesis.

5. Barrier Integrity and Aseptic Oversights: Biofilm Formation

Because pneumatic devices create hundreds of transient micro-channels that bypass the epidermal barrier, the risk of introducing surface pathogens into the mid-dermis is significant.

- **The Mistake:** Inadequate surface sterilization prior to treatment, or allowing patients to apply unsterile makeup or aggressive skincare actives immediately post-procedure. This can lead to secondary infections, delayed wound healing, or the formation of resilient biofilms.

- **The Prevention:** If your platform features Cold Plasma, utilize it thoroughly beforehand to sterilize the epidermal surface and increase tissue hydrophilicity. Post-treatment, maintain strict aseptic protocols: apply only sterile biocellulose masks or pure, medical-grade barrier repair agents, and enforce a strict 48-to-72-hour moratorium on makeup and non-sterile topicals.

Q11. What is the expected lifespan (shot count limit) for the Jet, Plasma, and EP Heads before replacement is required?

Maximum Shot Limit: Programmed for a maximum of 9,000 shots per nozzle. These are strictly classified as single-use medical consumables.

- **Cold Plasma (Time-Restricted):** This modality is capped at approximately 15 to 20 minutes of continuous emission. This is a hardcoded safety mechanism to prevent the internal piezoelectric transformer from overheating and to ensure that the trace ozone generated by ionizing the air remains safely below respiratory irritation thresholds.

- **Electroporation / EP (Usage-Restricted):** Electroporation does not have a continuous thermal time limit because it delivers microcurrents in discrete milliseconds, perfectly synced with the kinetic microjetting shots. Instead of a time limit, the EP function is restricted by the **physical lifespan of the polycarbonate tip**, which must be replaced every 5 to 10 patients to maintain hygiene and structural integrity.



Q12. How should clinics evaluate treatment economics and calculate consumable costs to maximize ROI?

Identifying the Complete Consumable Stack (True Variable Costs)

In a multimodal approach, hidden costs easily erode margins if not strictly tracked. You must calculate the aggregate cost of every item required to execute the protocol.

• **Strict Single-Use Disposables: the SynerJet Pro microjetting nozzle,**

The Biostimulatory Payload: The cost of the active ingredient delivered.

• Example: A vial of Poly-D,L-Lactic Acid (PDLLA) or exosomes

Amortized Multi-Patient Disposables: Items that have a finite lifespan but stretch across multiple patients.

• Example: The SynerJet EP (Electroporation) tips, which are replaced every 5 to 10 patients.

Implement Value-Based Packaging (The Revenue Lever)

Never itemize the cost of combination protocols to the patient. If you break down a quote as "\$X for the SynerJet, \$Y for the RF Microneedling, and \$Z for the PDLLA," you invite the patient to price-shop individual components and decline "optional" steps, which compromises the clinical outcome.

• **The Action:** Create branded, tiered packages. Sell the "Advanced Deep Scar Remodeling Program" or the "Global Glass Skin Protocol." Price the package based on the transformational value of the result, ensuring your total Cost of Goods Sold (COGS) remains strictly between 15% to 25% of the final package price.

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