



A Retrospective Series of 36 Cases Applying a Structured Face Fitness Methodology

Valeriia Veksler

CEO, Veksler Inc., Toronto, Canada.

ORCID: 0009-0001-7504-525X

Abstract

Non-surgical facial wellness practice has expanded quickly, yet the individual techniques it employs are far better documented than the reasoning that selects them. Manual release, facial exercise, lymphatic work and postural correction each carry their own literature; how a practitioner decides which of them a given client receives is largely undescribed. This paper reports a retrospective series of 36 anonymized client records documented in one non-medical facial wellness practice between March 2025 and June 2026, and asks a narrow question of them: how consistently do recorded assessment findings correspond to the protocol components subsequently assigned? Clients were aged 29 to 78 years (mean 55.0, SD 10.7). Every record prescribed daily home practice, with sessions of 10 to 15 minutes in 19 cases and 15 to 20 minutes in 16. Declared programme length ranged from three to seven weeks, with a median of four. Free-text entries were reduced to controlled vocabularies built separately for each field, yielding 14 finding codes from 129 phrases and 12 component codes from 59. A reference mapping of finding to indicated technique was derived from the practice methodology document and fixed in writing before the assigned-protocol column was examined. Protocols were individual to a degree that rules out a fixed routine: 34 distinct component combinations appeared across 36 cases, and 32 of them were used once. Assignment nonetheless followed the reference mapping closely for several findings, including masticatory tension to masseter release in 9 of 9 cases and neck or postural findings to cervical or postural work in 11 of 11. Because several components were prescribed in roughly half of all cases irrespective of findings, every proportion is reported against the rate observed when the same finding was absent, and mean coverage is benchmarked against protocols re-paired at random. One pre-specified correspondence ran opposite to expectation.

Keywords: Case Series, Content Analysis, Facial Wellness, Protocol Selection, Retrospective Records.

INTRODUCTION

Demand for non-surgical facial treatment has grown steeply, and the injectable and device-based end of that market has been quantified in some detail; Li et al. (2022) record a 621 percent increase in botulinum toxin use over the period they reviewed. The manual and exercise-based end of the same field has attracted far less description, despite being where unlicensed practitioners most often work.

The biological ground for that work is reasonably well mapped. Facial ageing involves loss and redistribution of soft tissue rather than surface change alone. Swift et al. (2020) report that temporal region thickness decreases by 3.4 mm with age while superficial temporal fat volume increases by 35.5 percent, and that elastin production declines after the age of 40. Coleman (2006) framed the volumetric account of facial ageing that later work refined; Mendelson (2012) documented the skeletal component, and Kruglikov et al.

(2016) the behaviour of the facial fat compartments. Fratila et al. (2016) review the combined picture.

Evidence for the specific techniques used in facial wellness practice is uneven. Alam et al. (2018) conducted the best-known randomized trial of facial exercise. Lim (2021) reviewed 11 studies of facial exercise and reported a median PEDro score of 3.5, which places the pooled methodological quality low; that review also notes improvement in mid-facial fullness after 20 weeks of practice and an average participant age below 50 years. Abe (2019) examined the effect of facial muscle training on the soft tissue profile, and Smith et al. (2020) survey non-invasive approaches more broadly.

Adjacent manual techniques carry their own bodies of evidence, some of it cautionary. Wu et al. (2021) pooled 8 randomized trials covering 375 patients and found no effect of myofascial release on quality of life, balance, pain threshold or trunk mobility, with heterogeneity of 46 percent for the

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pain analysis. Ajimsha et al. (2014), Laimi et al. (2017) and McKenney et al. (2013) reach similarly mixed conclusions across other conditions. Manual lymphatic drainage has been reviewed by Ezzo et al. (2015) and Vairo et al. (2009); Oliveira et al. (2018) followed 106 women over 30 months and recorded a cumulative lymphoedema incidence of 23.8 percent. For the masticatory muscles, Urbański et al. (2021) measured surface electromyographic activity of the temporal muscles falling from 251.5 μV to 186.6 μV and of the masseter from 239.4 μV to 187.4 μV following manual technique, alongside a fall in pain intensity from 5.0 to 2.0 on a visual analogue scale. Olchowy et al. (2022) recorded masseter stiffness in 35 patients dropping from 12.17 kPa to 7.96 kPa during conservative therapy. Kalamir et al. (2010), Calixtre et al. (2015) and Chan et al. (2022) address manual and conservative management of temporomandibular disorders. The cervical spine connects to this picture: Armijo-Olivo (2012) reports a correlation of 0.82 between neck and jaw disability, Gomes et al. (2013) review craniocervical posture against craniofacial morphology, and Singla (2017) and Matheus et al. (2009) describe the postural associations.

What this literature does not describe is the selection step. A practitioner facing a client with jaw tension, lymphatic congestion and a poorly defined jawline must decide which techniques that client receives, and the published record offers no account of how such decisions are made or whether they are made consistently. Structured commercial methodologies exist and train practitioners in a documented assessment sequence, but their internal logic is rarely examined against their own case records.

This paper takes one such methodology and asks a deliberately narrow question of its documentation. Rather than testing whether the method works, it asks whether the documented decisions are internally coherent: given what the practitioner recorded at assessment, can the protocol she assigned be predicted from the methodology's own logic more closely than the frequency of each technique alone would produce? That question can be answered from retrospective records. Questions of effectiveness cannot.

MATERIALS AND METHODS

Design and Reporting

This is a retrospective descriptive case series analysed cross-sectionally. Reporting follows the STROBE statement for cross-sectional studies (Vandenbroucke et al., 2007), supplemented by case-series items discussed by Murad et al. (2018) and by the provenance items relevant to routinely collected records set out by Benchimol et al. (2015).

Because assessment, protocol assignment and documentation were performed by the same individual, this analysis evaluates the internal consistency of documented decisions, not inter-practitioner reproducibility.

Setting and Cases

Records come from a single practitioner in a non-medical

facial wellness practice in Toronto, Canada. Thirty-six case records covering March 2025 to June 2026 were released for analysis, identified as C01 to C36. No case was excluded once released.

These 36 records represent a documented subset of the practice's caseload over the period rather than a consecutive series, and the criterion by which they were selected for documentation was not recorded. This limits what the series can represent and is treated as a constraint on interpretation throughout. Figure 1 sets out the route from released records to the datasets analysed below.

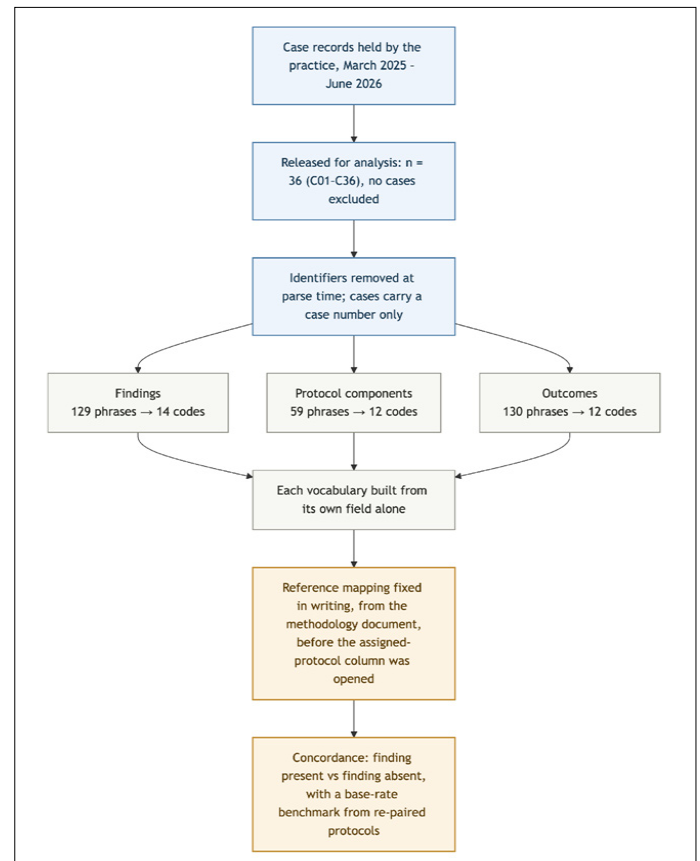


Figure 1. Flow from released case records to analysis datasets. Each controlled vocabulary was constructed from the phrases of its own field alone, and the reference mapping was fixed in writing before the assigned-protocol column was opened.

Data Provenance

Each record carries face type, age, start and end date, initial assessment findings, client-reported concerns, assigned protocol with recommended frequency, declared duration, and a final assessment. The source workbook also held a column linking each case to publicly visible social-media material and, in 20 cases, to a personal name. That column was discarded at the point the workbook was read and appears in no derived file; cases carry a case number and nothing else.

Two provenance features affect how dates should be read. In 16 records, C21 to C36, both start and end dates fall on the first day of a month in a regular monthly cadence,

indicating dates recorded to the nearest month rather than contemporaneously; those dates should be read as approximate. Declared programme duration agreed with the calendar interval to within one week in 29 records, exceeded it by exactly one week in six (C06 to C11), and exceeded it by 1.7 weeks in one (C20). Declared duration is treated as the prescribed programme length and the calendar interval as secondary.

Records were generated during routine non-medical wellness practice and analysed retrospectively in anonymized form. No clinical intervention was involved, no research ethics committee review was sought, and identifying material was removed before analysis.

Controlled Vocabularies

Entries in all four free-text fields were uncontrolled, with the same concept written several ways across records. Reduction to a controlled vocabulary was therefore a substantive analytic step rather than data preparation, and is reported as such.

Three vocabularies were built. Codes were anchored on the categories the practice methodology document itself lists:

Table 1. Reduction of free-text entries to controlled vocabularies. Codes were anchored on the categories listed in the practice methodology document; residual codes were added only where a phrase would not fit an existing category. Concerns were coded with the findings code set extended by 43 concern-only phrases.

Field	Unique phrases	Codes	Mentions	Mean per case
Assessment findings (practitioner-observed)	129	14	163	4.5
Main concerns (client-reported)	60	14 + 1	108	3.0
Protocol components	59	12	141	3.9
Final-assessment statements	130	12	177	4.9

Reference Mapping

Measuring consistency requires a statement of which technique each finding indicates. The methodology document does not contain one. It lists assessment domains and technique families separately and states only that the exact combination of techniques is determined by the client's assessment and is individualized for each case.

A reference mapping was therefore constructed from the document's own logic rather than quoted from it, and was fixed in writing before the assigned-protocol column was opened. Six correspondences follow directly from the document naming both sides: lymphatic congestion to lymphatic drainage, fascial restriction to myofascial release, muscular weakness to activation exercises, neck and shoulder tension to cervical release or postural work, masticatory tension to masseter release, and general muscular tension to relaxation or myofascial release. Five further correspondences are implied by the document's logic without being stated, and are reported separately as inferred. Three finding codes, including facial asymmetry, were left unmapped because the document supports no technique for them, even though the records contain symmetry exercises. Five negative-control

nine assessment domains, nine technique families, and seven follow-up domains. Residual codes were added only where a phrase would not fit an existing category. Each vocabulary was constructed by reading the phrases of its own field alone, so the protocol coding could not have been shaped by the finding coding or the reverse. Coding was then a deterministic dictionary lookup, and every phrase resolved.

The findings vocabulary reduced 129 unique phrases to 14 codes, the protocol vocabulary 59 phrases to 12 codes, and the outcome vocabulary 130 phrases to 12. Client-reported concerns were coded with the findings code set extended by 43 concern-only phrases. One distinction required care: contour vocabulary such as "reduced jawline definition" denotes lower-face support rather than masticatory function, and conflating the two would have inflated the masticatory domain from 9 cases to 22.

Coding was performed by a single coder. Inter-rater reliability was not assessed, a limitation discussed by McDonald et al. (2019) and returned to below. Table 1 summarises the reduction of each field; the complete phrase-to-code mappings accompany the analysis code. All three vocabularies were fixed before analysis.

pairs, linked by the methodology in no way, were specified in the same act.

The mapping was pre-specified prior to analysis but was not pre-registered and was not separately confirmed by the developer of the method. Because the method is individualized by design, the reference names the primary indicated technique or techniques per finding rather than a mandatory rule, and departure from it is not treated as error. A case counts as concordant for a finding when at least one indicated component was assigned.

Analysis

Analysis is descriptive and exploratory. No confirmatory hypothesis test is reported, no multiplicity correction is applied, and no p-value is presented as a result.

Two devices carry the argument. First, several components were assigned in roughly half of all cases irrespective of findings, so a raw conditional proportion overstates correspondence. Every pair is therefore reported against the rate among cases where the same finding was absent, which is the honest comparator; the overall rate contains the finding-present cases and is contaminated. Second, mean

coverage across cases was compared with a distribution generated by re-pairing the 36 observed protocol sets with the 36 observed finding profiles at random, 10,000 times. That permutation preserves each component's frequency exactly, so the resulting distribution already contains all the correspondence that component frequencies alone can produce.

Single proportions carry Clopper-Pearson exact 95% intervals, which behave at the boundary counts this dataset produces; differences carry Newcombe hybrid-score intervals. Intervals are reported for the comparative concordance analysis only. Counts that describe the sample itself, in Tables 2 and 4 and in the outcome-domain frequencies, are given as plain numerators over denominators, because no comparison

is drawn from them. Intervals describe the precision of the observed series and support no inference to any wider population. The analysis was repeated with components collapsed to the nine technique families of the methodology document as a sensitivity check on codebook granularity.

RESULTS AND DISCUSSIONS

The Series

Table 2 describes the 36 cases. Clients were aged 29 to 78 years, with a mean of 55.0 (SD 10.7) and a median of 56.5. Practitioner-assigned face type, an adaptation of body somatotype terminology to facial morphology that has not been validated, divided the series into 13 mesomorph, 13 endomorph and 10 ectomorph cases.

Table 2. Characteristics of the 36 documented cases, March 2025 to June 2026.

Characteristic	Value
Age, years	mean 55.0 (SD 10.7); median 56.5; range 29 to 78
Face type (practitioner-assigned, not validated)	Mesomorph 13; Endomorph 13; Ectomorph 10
Declared programme length, weeks	3 wk: 4; 4 wk: 20; 5 wk: 4; 6 wk: 6; 7 wk: 2 (median 4)
Calendar interval, days	median 31; range 21 to 53
Prescribed frequency	daily in 36 of 36 records
Prescribed session length, minutes	10-15: 19; 15-20: 16; 20-25: 1
Dates recorded to the nearest month	16 records (C21 to C36)

Prescription parameters were near-uniform. All 36 records prescribed daily home practice. Session length was 10 to 15 minutes in 19 records, 15 to 20 minutes in 16, and 20 to 25 minutes in one. Declared programme length ran from three to seven weeks with a median of four, and the calendar interval had a median of 31 days. Figure 2 shows the programme windows, in which the monthly cadence of the 16 month-approximate records is visible.

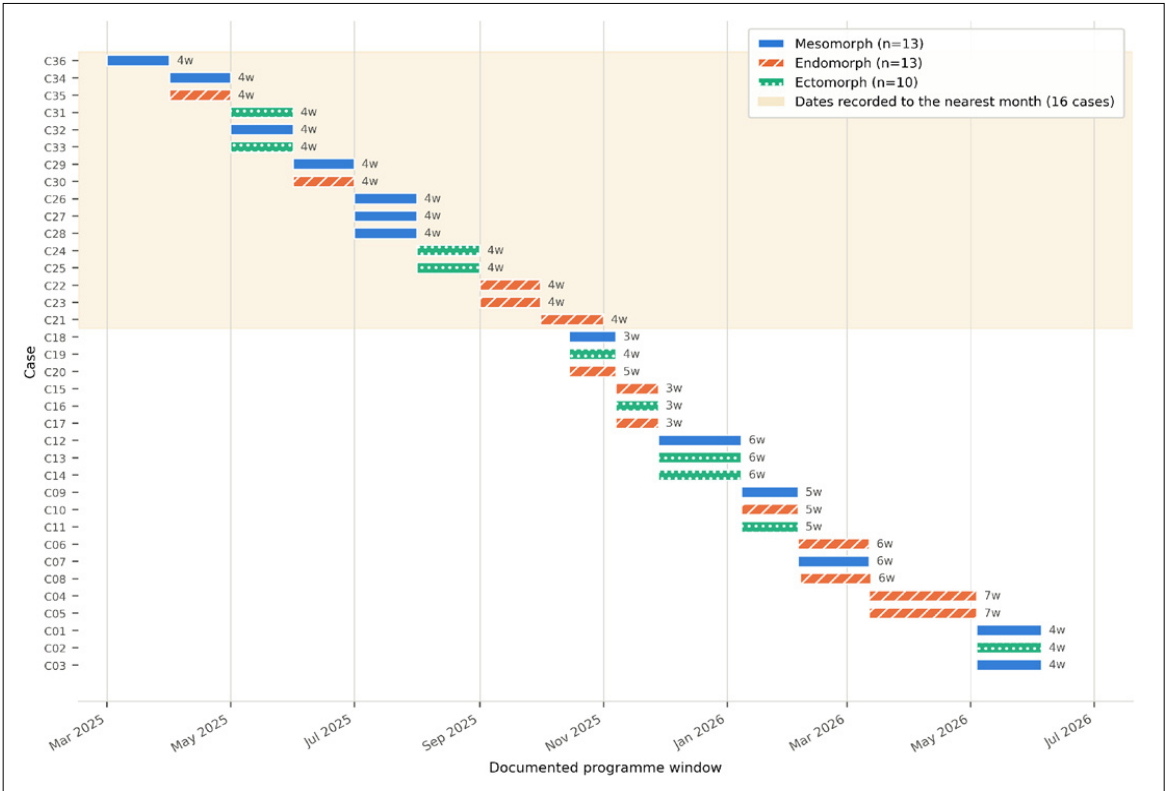


Figure 2. Documented programme window for each case, shaded by practitioner-assigned face type. The shaded band marks the 16 records whose start and end dates fall on the first of a month in a regular cadence, indicating dates recorded to the nearest month rather than contemporaneously. Labels give declared programme length in weeks.

Protocols were Individual

Across 36 cases the records contain 34 distinct verbatim combinations of protocol components. Thirty-two of those combinations appear exactly once, and none appears more than twice. After reduction to the controlled vocabulary, 27 distinct component sets remain, 20 of them used once. Cases received a mean of 3.53 coded components, ranging from two to six.

The methodology document claims that it delivers an individualized approach rather than a standardized routine. These counts are what that claim looks like when checked against the practice's own records, and they support it.

Assignment Followed the Reference Mapping for Most Findings

Table 3 reports concordance for each mapped finding against the rate observed when that finding was absent, and Figure 3 shows the full finding-by-component matrix with the pre-specified cells outlined.

Table 3. Concordance between recorded assessment finding and assigned protocol component, against the rate observed when the same finding was absent. Explicit pairs follow from the methodology document naming both sides; inferred pairs are implied by its logic without being stated; negative controls are pairs the methodology links in no way and were specified in the same act as the mapping. Single proportions carry Clopper-Pearson exact 95% intervals, differences Newcombe hybrid-score intervals. Intervals describe the precision of this series and support no wider inference.

Type	Finding	Indicated component	Present	Proportion (95% CI)	Absent	Difference (95% CI)
Explicit	Lymphatic congestion	Lymphatic drainage	16/18	0.89 (0.65 to 0.99)	0.33	+0.56 (0.24 to 0.74)
Explicit	Fascial restriction	Myofascial release (general)	4/9	0.44 (0.14 to 0.79)	0.11	+0.33 (0.03 to 0.63)
Explicit	Muscular weakness	Lifting / toning exercises	1/4	0.25 (0.01 to 0.81)	0.66	-0.41 (-0.65 to 0.08)
Explicit	Neck / shoulder / postural	Neck / cervical release or Posture correction	11/11	1.00 (0.72 to 1.00)	0.36	+0.64 (0.32 to 0.80)
Explicit	Masticatory tension	Masseter / temporalis release	9/9	1.00 (0.66 to 1.00)	0.37	+0.63 (0.28 to 0.78)
Explicit	General muscular tension	Facial relaxation or Myofascial release (general)	5/10	0.50 (0.19 to 0.81)	0.15	+0.35 (0.03 to 0.63)
Inferred	Upper-face tension	Forehead release	5/6	0.83 (0.36 to 1.00)	0.00	+0.83 (0.42 to 0.97)
Inferred	Periocular changes	Periocular release	5/10	0.50 (0.19 to 0.81)	0.04	+0.46 (0.16 to 0.73)
Inferred	Circulation impairment	Circulation stimulation	3/14	0.21 (0.05 to 0.51)	0.18	+0.03 (-0.21 to 0.32)
Inferred	Lower-face laxity	Lifting / toning exercises	18/22	0.82 (0.60 to 0.95)	0.29	+0.53 (0.20 to 0.73)
Inferred	Mid-face volume loss	Lifting / toning exercises	10/13	0.77 (0.46 to 0.95)	0.52	+0.25 (-0.08 to 0.49)
Negative control	Masticatory tension	Periocular release	1/9	0.11 (0.00 to 0.48)	0.19	-0.07 (-0.28 to 0.27)
Negative control	Periocular changes	Masseter / temporalis release	3/10	0.30 (0.07 to 0.65)	0.62	-0.32 (-0.57 to 0.04)
Negative control	Lower-face laxity	Forehead release	0/22	0.00 (0.00 to 0.15)	0.36	-0.36 (-0.61 to -0.11)
Negative control	Upper-face tension	Posture correction	0/6	0.00 (0.00 to 0.46)	0.33	-0.33 (-0.51 to 0.08)
Negative control	Lymphatic congestion	Symmetry / balancing exercises	3/18	0.17 (0.04 to 0.41)	0.06	+0.11 (-0.12 to 0.34)

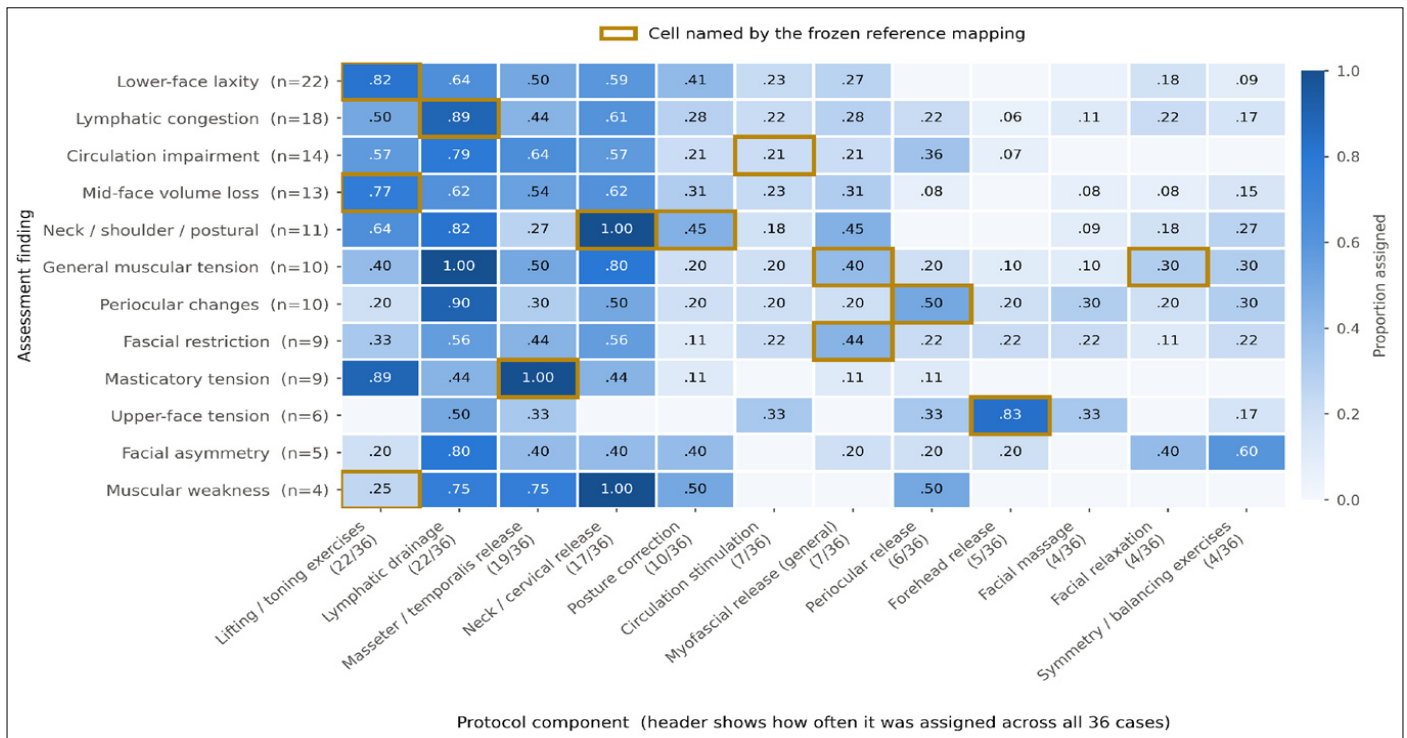


Figure 3. Proportion of cases carrying each assessment finding that received each protocol component. Column headers give how often each component was assigned across all 36 cases, so every cell can be read against its own base rate. Outlined cells are those named by the reference mapping fixed before the assignment data was examined; the remaining cells are shown so that the whole matrix, and not only the pre-specified part of it, is visible. Findings recorded in fewer than four cases are omitted.

Three explicit correspondences were strong. Throughout this section, “strong” and “moderate” describe the size of the difference and the width of its interval, not statistical significance; no significance test was performed. Masticatory tension was followed by masseter or temporalis release in 9 of 9 cases, 1.00 (95% CI 0.66 to 1.00), against 0.37 when the finding was absent, a difference of 0.63 (95% CI 0.28 to 0.78). Neck, shoulder or postural findings were followed by cervical release or postural work in 11 of 11 cases, 1.00 (0.72 to 1.00), against 0.36, a difference of 0.64 (0.32 to 0.80). Lymphatic congestion was followed by lymphatic drainage in 16 of 18 cases, 0.89 (0.65 to 0.99), against 0.33, a difference of 0.56 (0.24 to 0.74).

Two were moderate. Fascial restriction was followed by myofascial release in 4 of 9 cases, 0.44 (0.14 to 0.79), against 0.11, a difference of 0.33 (0.03 to 0.63); general muscular tension by relaxation or myofascial release in 5 of 10, 0.50 (0.19 to 0.81), against 0.15, a difference of 0.35 (0.03 to 0.63).

The sixth explicit correspondence ran opposite to expectation. Muscular weakness was followed by lifting or toning exercises in only 1 of 4 cases, 0.25 (0.01 to 0.81), against 0.66 when the finding was absent, a difference of -0.41 (95% CI -0.65 to 0.08). Four cases cannot settle anything and the interval crosses zero, but the direction is worth stating plainly rather than omitting: the one correspondence a reader would consider most obvious, weakness answered by activation, is the one the records do not show. A plausible reading is that the practitioner treats explicit weakness

notes as descriptions of an already-evident support deficit that the lifting work addresses under a different label, since lifting exercises were assigned in 22 of 36 cases overall. That reading is speculation and the data cannot test it.

Among the inferred correspondences, upper-face tension was followed by forehead release in 5 of 6 cases against 0 of 30 when absent, and periocular findings by periocular release in 5 of 10 against 1 of 26. Lower-face laxity was followed by lifting or toning work in 18 of 22, 0.82 (0.60 to 0.95), against 0.29. Mid-face volume loss showed a weaker difference of 0.25 (-0.08 to 0.49), and circulation impairment showed none at all: 3 of 14 against 4 of 22, a difference of 0.03 (-0.21 to 0.32). Circulation appears often as an assessment observation but does not drive a circulation-specific technique.

Correspondence Exceeds what Technique Frequency Alone Produces

Because lifting exercises and lymphatic drainage were each assigned in 22 of 36 cases, high conditional proportions could arise without any decision rule at all. The permutation benchmark addresses this directly. Observed mean coverage across the 29 cases carrying at least one explicitly mapped finding was 0.680. Re-pairing protocols with finding profiles at random 10,000 times produced a distribution centred on 0.427 with a standard deviation of 0.062, a 95th percentile of 0.528 and a maximum of 0.637. The observed value exceeded every one of the 10,000 re-pairings. Including the inferred correspondences, observed coverage across all 36 cases was

0.694 against a null centred on 0.408 with a maximum of 0.573.

The negative controls behave as they should. Lower-face laxity was followed by forehead release in 0 of 22 cases against 5 of 14 when absent; upper-face tension by postural correction in 0 of 6 against 10 of 30; masticatory tension by periocular release in 1 of 9 against 5 of 27. None of the five pre-specified unrelated pairs produced a positive difference, which is what distinguishes a decision rule from a general tendency to prescribe more of everything.

Collapsing the component vocabulary to the nine technique families of the methodology document changed mean coverage from 0.680 to 0.697, so the result does not depend on how finely the vocabulary was cut.

These figures say something narrow. They say that one practitioner's documented protocol assignment tracks her own assessment findings in a way that random re-pairing

Table 4. Protocol composition by practitioner-assigned face type, as counts of cases receiving each component out of cases of that type. No comparison between types was performed: the cell counts do not support one, and any such comparison would presuppose the validity of a classification that has not been established.

Protocol component	Mesomorph (n=13)	Endomorph (n=13)	Ectomorph (n=10)
Lifting / toning exercises	7/13	8/13	7/10
Lymphatic drainage	9/13	9/13	4/10
Masseter / temporalis release	4/13	10/13	5/10
Neck / cervical release	4/13	7/13	6/10
Posture correction	4/13	2/13	4/10
Circulation stimulation	4/13	1/13	2/10
Myofascial release (general)	3/13	2/13	2/10
Periocular release	2/13	2/13	2/10
Forehead release	3/13	1/13	1/10
Facial massage	1/13	2/13	1/10
Facial relaxation	3/13	1/13	0/10
Symmetry / balancing exercises	3/13	1/13	0/10

What the Final Assessments Record

Final assessments were coded into 12 outcome domains. Support and contour language appears in 30 of 36 records, circulation or complexion language in 21, puffiness in 15, symmetry in 14, muscular tension in 13, and reduced jaw tension in 5. Frequencies describe documentation, not measured change.

One property of these records governs how they may be read. All 177 final-assessment statements across all 36 cases are improvement statements. No record contains a statement of non-improvement, partial improvement, adverse event or withdrawal, and all 36 programmes are recorded as completed. Because the records were written by the treating practitioner without a standardized outcome form, the absence of such statements cannot be read as their absence in the clients. This is a property of the documentation and is reported as one; it is not a response rate and must not be read as one.

does not reproduce, and that the correspondence follows a mapping written down before the assignments were examined. They say nothing about whether any assigned technique helped anyone.

Face Type

Table 4 reports protocol composition by face type as counts. Masseter or temporalis release appears in 10 of 13 endomorph cases against 4 of 13 mesomorph, and lymphatic drainage in 9 of 13 endomorph and 9 of 13 mesomorph against 4 of 10 ectomorph. No comparison between face types was performed. With 10 to 13 cases spread across 12 component codes the resulting cell counts do not support one, and any such comparison would presuppose the validity of a classification that has not been established. Establishing inter-rater reliability of face-type assignment is a prerequisite for any future use of the category and was not possible in retrospective records.

The uncontrolled vocabulary is itself informative. The practice generated 130 distinct phrasings for 177 outcome statements, a ratio that shows documentation was never standardized at the level of wording even though the workflow was standardized at the level of process. A controlled outcome vocabulary is the cheapest available improvement to this practice's record-keeping, and the code set summarised in Table 1 is a starting point for one.

Relation to the Wider Literature

The techniques in these protocols have evidence bases of varying strength, and assignment does not track that strength. Masticatory work is the best supported; Urbański et al. (2021) and Olchoway et al. (2022) both report measurable change in masseter state under manual technique, and Armijo-Olivo (2012) reports a neck-to-jaw disability correlation of 0.82, which makes the near-perfect neck-to-cervical-work correspondence here unsurprising. Myofascial release fares worse in pooled analysis, with Wu et al. (2021)

finding no effect across several outcomes in 8 trials and 375 patients, yet it reaches fewer than half the cases showing fascial restriction. Facial exercise, the component assigned most often, rests on a literature that Lim (2021) scores at a median PEDro of 3.5.

That mismatch is the practical finding for practitioners. A framework can be internally consistent, as this one demonstrably is, while the components it consistently selects vary widely in external support. Consistency of process and strength of evidence are separate properties, and demonstrating the first says nothing about the second.

Limitations

This design cannot support any statement about effectiveness, and none is made. There is no control group, no comparison condition and no blinding of any kind, and the series has no measured outcome: no validated instrument, no client-reported outcome measure, no photographic analysis, no follow-up beyond the end of the programme.

Assessment, protocol assignment, outcome documentation and the practice methodology all originate with one individual, who is also the author. The consistency measured here is consistency of one person with her own framework. A concordance this high is equally compatible with the records having been written to be internally coherent, whether at the time or in reconstruction, and the month-approximate dating of 16 records shows that at least part of the set was compiled after the fact. Inter-practitioner reproducibility is the question of real interest and this design cannot reach it; a study across independently trained practitioners is the necessary next step, and the certification cohorts of the practice make it feasible.

The reference mapping was constructed rather than quoted, because the methodology document contains no crosswalk. It was fixed before the assignment data was examined and its full contents are reported, but it was not pre-registered and the developer of the method did not confirm it independently. Coding was performed by a single coder without a reliability estimate.

The 36 records are a documented subset of the caseload, not a consecutive series, and the selection criterion was not recorded. Combined with uniformly positive outcome documentation, this means the series cannot be read as representative of the practice, still less of the field.

Face type is a practitioner-assigned category adapted from body somatotype terminology with no validated facial analogue known to the author, assigned by a single unblinded practitioner with no reliability data.

CONCLUSIONS

Thirty-six documented cases from one facial wellness practice show protocols that are individual in composition and, at the same time, systematic in how they are chosen. Thirty-four distinct component combinations across 36 cases

rule out a fixed routine, while assignment tracks recorded assessment findings closely enough that random re-pairing of protocols to findings never reproduced it across 10,000 attempts, and pre-specified unrelated pairs showed no such correspondence.

The correspondence is not uniform. It is near-total for masticatory and cervical findings, moderate for fascial and general tension, absent for circulation, and inverted for the one finding where an obvious answer existed. Reporting those weaker cells matters as much as the strong ones, because a framework that matched expectation everywhere would be evidence of a fitted analysis rather than a documented practice.

What this series establishes is that a structured assessment-to-protocol framework can be documented well enough for its internal logic to be audited from ordinary practice records. It establishes nothing about whether the protocols work. Those are separate questions, and only the first is answerable from records of this kind.

Data and Code Availability

The underlying case records are anonymized client documentation held by the practice and are not publicly available, since they were generated in the course of commercial service delivery rather than for research release. The controlled vocabularies, the reference mapping, the coded case-level dataset stripped of all identifiers, and the analysis and permutation code are available from the author on reasonable request.

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