

Original ISAPS Congress Abstract Book Found **Cristino Suárez López de Vergara – Spain**

A rare book was found by Dr. Miguel Chamosa Martin from Madrid, Spain when he was looking for something around old furniture at an antique shop. Suddenly, he saw a discarded book on some shelves, which turned out to be the Abstract Book of the First ISAPS Congress held in Rio de Janeiro on February 6-11, 1972.

While I was spending a week at Miguel's home last June, he showed it to me. I was surprised to see this jewel with works from the fathers of plastic surgery. Miguel was so impressed by my reaction that he decided to give it to me as a present. Keeping the book for myself would have been very selfish of me, so I have decided to share it with the International Society of Aesthetic Plastic Surgery.

This is one way to honor my friend and mentor Dr. Ulrich Hinderer whose important contribution to ISAPS has helped us get where we are now.



ABSTRACT BOOK

FIRST INTERNATIONAL CONGRESS



Rio de Janeiro - FEB. 6-11, 1972

**FIRST CONGRESS
INTERNATIONAL SOCIETY
OF AESTHETIC PLASTIC SURGERY**

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FIRST CONGRESS

RIO DE JANEIRO, Brasil, Feb. 6th to 11th, 1972

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FOREWORD

TO THE SCIENTIFIC PROGRAM

On behalf of the Scientific Program Committee, I welcome you to this First International Congress of Aesthetic-Plastic Surgery. It is my hope that the organization of the Scientific Program will approach the level of the numerous excellent contributions received, and that this event will serve to illustrate both the range and importance of this significant field of medicine.

As this is the first congress of the recently formed International Society of Aesthetic-Plastic Surgery, a program (including techniques, complications and pitfalls concerning several subjects) was selected to give a fair general view of the specialty. The inclusion of very specific problems and promotion of research was considered to be more appropriate for further congresses.

Outstanding specialists from more than 30 countries all over the world unstintingly offered their cooperation for the panels and papers concerning the main topics of THE AGING FACE, REDUCTION MAMMAPLASTY, RHINOPLASTY and PROTRUDING EARS. Together with other free papers and films submitted, these provide the necessary information concerning recent developments in techniques. There is no doubt that we are entering a new period in our field when the refinement in diagnosis and technology based on scientific development and experience brings all of us closer to the perfection which distinguishes the image of the specialized plastic surgeon dedicated to aesthetic surgery before the medical profession and the public at large.

But also papers were invited on the psychological aspect of our specialty, as the «Leitmotiv» of the individual's desire for a surgical improvement in appearance or for retaining youth and so overcoming aging and stress of life is psychic, sometimes conscious, sometimes subconscious. The patient seeking aesthetic surgery wishes to regain self-confidence, security and a better adjustment to life when the image of himself, his vitality or the grace of his appearance, in his family, professional or social environment are fundamentally in doubt. An aesthetic operation may be a vital necessity if it succeeds in restoring the patient's life in the total sense, for life is not only biological and biographical —an isolated individual unity—, but also psychic and social in Heidegger's sense of coexistence. But it must be emphasized that it is necessary to know beforehand whether the patient will improve mentally if the total result is to correspond to the surgical improvement. Aesthetic surgery is therefore not only a technical specialty, but moreover a science closely related to psychotherapy and art as well. In addition, the first afternoon session includes, besides a brief history on aesthetic plastic surgery, a lecture on the arts, which stresses the need for artistic principles in our field. The aesthetic-plastic surgeon from this point of view requires a knowledge of the artistic canons of beauty, of the ideal proportions of the human face and body as well as a knowledge of the varied appearance and aesthetic ideals of each ethnic group, in order to be able to apply them in surgery. This demands a certain artistic sensibility with regard to harmony and proportion which, though it has to be improved constantly by study, must exist naturally.

Moreover a round table was included to emphasize the training necessary for a technical and general education in this field. In order to establish, if possible, to reach standards concerning the requirements and duration of training, it is necessary to know their present status in all continents. Although there is a general agreement upon the necessity of a previous training in basic surgery and plastic surgery before dedication to aesthetic surgery, there is no unanimity

yet concerning duration, etc. It was also felt opportune to receive suggestions on how to protect this field for the benefit of all those who are seeking aesthetic corrections. There is definitely a need to find the right way of promotion in many countries in order that the public be aware of a well-trained medical profession dedicated to aesthetic-plastic surgery in which they can confide, as well as need to increase the appreciation of the medical profession and to augment the awareness of the role of aesthetic-plastic surgery in medical practice.

We decided to hold the Congress in one auditorium in order to avoid conflicting sessions. Therefore the program is intensive. Aside from invited papers, panel, film and round table contributions, only one paper could be admitted from each participant and even so, several could only be read by title. All papers, however, are included in the Abstract Book and can be published in the Transactions. I regret that all papers could not be included in the program; the eventual displeasure of friends will, I hope, be compensated by a more efficient and constructive congress.

The Transactions will be published according to a new concept of communication, Microform. As one does not have the printed text, however, I therefore decided to publish the summaries in a slightly longer form in order to give a more extensive idea of the content of a paper than is usually received from the customary short abstracts. The reverse side of the summaries is left free for personal notes during the Congress. The abstracts may be torn out and filed according to the system I had the opportunity of introducing in the **Spanish Journal of Plastic Surgery**, later on adopted by others. Members of the round table and film contributors are only listed, as it is planned to publish the first of these contributions together with the discussions, in microform. I must apologize if the summaries do not have a uniform length or if I failed to transmit the exact idea of the writer. Due to the extremely short time available for preparing the Congress, it was impossible to return delayed abstracts for correction and many summaries had to be revised. By the way, we took the liberty of substituting the term «aesthetic» for «cosmetic» whenever it was mentioned, as the meaning of «cosmetic» (from the Greek «kosmein») is essentially that of adorning, decorating and make-up, but it always refers to the complexion and the chemical products for skin care.

I wish to thank the Chairmen of the Scientific Program Committee, Dr. González-Ulloa and Dr. Ohmori, for their help and suggestions; also the Chairman of the Organising Committee, Dr. Serson, with whom I have been in a constant contact.

Finally, on behalf of the Scientific Program Committee, I wish to thank the plastic surgeons of all continents whose interest in this field, whose cooperation and fine contributions made the celebration of this Congress possible.

Let us hope that it will inaugurate an abiding tradition and contribute to the future of aesthetic-plastic surgery in a growing number of countries throughout the world.

My very best wishes to all of you.

Ulrich Hinderer

Chairman of the Scientific
Program Committee

A HISTORY OF AESTHETIC-PLASTIC SURGERY

GONZALEZ-ULLOA, M.

The authors, after carrying out an exhaustive investigation of all literature of several branches of aesthetic-plastic surgery in the Index Medicus, Cumulative Index, Current List of Medical Literature, Cumulative Subjects and Author's Indexes, Quarterly Cumulative Index Medicus, Index Catalogue of the Library of the Surgeon General's Office, the U.S.A. Army from 1880 to 1970, chose the themes of rhytidectomy, rhinoplasty and trunk operations for description of the history of aesthetic-plastic surgery.

They cover the philosophical and psychological trends, as well as the ideas that have prevailed through time and describe the changes in technical performances.

Due to the short time allotted, the description is reduced and lacks, naturally, a large group of important authors whose works and endeavours have been decisive in the shaping of this specialty.

All the material of the investigation will form, in due time, a book, with the same title, in which due credit will be given to all authors who have contributed to the specialty.

NEW CONCEPTS OF COMMUNICATION IN MEDICAL WORLD LITERATURE AND ESPECIALLY IN AESTHETIC PLASTIC SURGERY

TAMERIN, J. A.

The transactions of this First Congress of the International Society of Aesthetic Plastic Surgery are to be published in a revolutionary new form, the microform. The microform presentation will be black and white microfiche, in the largest part, though a few articles will appear in coloured microfiche. The reduction ratio will be from 60 pages to a fiche (card) to 98.

Since the film reproduces illustrations as easily and exactly as it does type-written script, the usual limitation on the number of illustrations is reversed. Authors are encouraged to use illustrations profusely.

Miniturization and profusion of illustration are matched by the relative low cost of publication.

As soon as new microfiche readers are available, the market for this method of communication will expand enormously. Eastman Kodak Company of America is largely responsible for the newer technology and will probably be responsible for the change in communication in many fields beside medicine from the printed page with cuts for illustration, to microfiche. The reduction ratios are even higher than 100 to one and the end of the crowded library is in sight. Many commercial firms use microfiche instead of printed catalogues and the end of the printed journals in technical fields such as medicine is prophesized by the end of this century. Books will be mainly used in technical fields as indices and reference manuals.

In addition, cassette for translation is another aspect of this revolution in communication. Simultaneous use of a cassette translation of a microfiche permits the reader to use the illustrative material and yet does not require a large investment in equipment, since simultaneous translation is almost 'de rigueur' in many congresses and such translations recorded on cassette can now be easily duplicated with new machines in small volume and at very little cost.

PSYCHOLOGICAL BASES OF AESTHETIC SURGERY

BERNDORFER, A.

Aesthetic surgery cannot be considered exclusively as a technical-methodological intervention. There are relatively few patients who visit the plastic surgeon only because of visible aesthetic defects. The desire to change the body has psychical motives in most of the cases. Somebody who wants to have an aesthetically deformed part of his body (usually on the face) operated on, has a feeling of being suppressed in the society and he has inhibitions which even may lead to serious psychoses. Even little children request an operation for protruding ears, in order to avoid the sneer of their playmates. Wrinkles of the face caused by ageing may be the origin of inhibitions and of psychical problems, the deeper reasons of which have to be exactly investigated by analysis. Aesthetic surgery can be considered as a special kind of therapy and therefore it is necessary that the plastic surgeon exactly recognize every psychical motive in order to gain «recovery». The origin of so-called surgical beautifying can be found in the traditional corporeal changes of primitive races, which offer an analogy to the operations carried out in civilized ones. In this sense, aesthetic surgery advances from a technical-methodological intervention to a special science of therapy.

INTERPERSONAL RELATIONSHIPS IN AESTHETIC PLASTIC SURGERY

REICH, J.

The importance of psychological factors in determining an individual's desire for a surgical improvement in appearance is generally appreciated by aesthetic plastic surgeons.

Less well-defined is the importance of interpersonal relationships between the individual requesting aesthetic plastic surgery and his family, close friends, acquaintances or casual contacts.

The special role of the aesthetic plastic surgeon in the patient's quest for an improved appearance is defined and demands not only expertise and technical skill in this field of surgery, but the development of a particular kind of doctor-patient relationship which must be established prior to operation and maintained through the operative and postoperative phases.

The attitude of the patient's general medical adviser to a request for referral to an aesthetic plastic surgeon is discussed and his resistance to such a request analysed.

The attitude of others to an individual's desire for a surgical improvement in appearance has been studied with particular emphasis on the interplay of the personal, psychological and aesthetic factors which influence these.

It is concluded that the reaction of the individual undergoing aesthetic plastic surgery, to the attitudes of others, exerts a significant influence during the postoperative period. It was also found to be the basis of satisfaction or otherwise with the result of operation, often irrespective of the purely aesthetic outcome.

A solution to the problems created by adverse interpersonal relationships in aesthetic plastic surgery is formulated and the need for adequate preoperative communication with the patient and his close contacts is stressed. In this context, the need to increase the appreciation of the medical profession as a whole as well as that of the public, to the aims of aesthetic plastic surgery and its role in medical practice is noted and the directions in which this can be achieved, explored.

AESTHETIC SURGERY IN RELATION TO PSYCHIATRIC PROBLEMS

MATTHEWS, D.

Aesthetic Surgery means to me an attempt at the restoration of form which has deteriorated with ageing or is unacceptable to the patient as a racial characteristic. It includes rhytidectomy, reduction and augmentation mammoplasty, rhinoplasty, abdominal lipectomy, the correction of sagging limb contours and bat ears. Plastic surgeons also perform many other operations designed to improve appearance. These may result from injuries or disease, or congenital malformations. But the decision for or against surgery in these is usually dictated only by the degree of improvement which it is technically possible to make. With aesthetic surgery there are non-surgical overtones in almost every case, and to arrive at the right decision demands special skills and judgement imposing much responsibility on the surgeon to ensure that he only operates on patients who will benefit mentally as well as physically. It is his duty to avail himself of the help of the patient's physician and if necessary of a consultant psychiatrist as well, and to hear the views of the patient's family.

The motives leading patients to seek aesthetic surgery are many and varied. They are conscious and subconscious. Of the conscious motives the commonest are the desire to perpetuate youth, the fear, real or supposed, of the loss of personal or social acceptability, the need to keep a job, the desire to disguise ethnic origin and, rarely, the intent to conceal detection by a criminal. The subconscious motives are the outcome of the inability of an inadequate personality to face the challenges of daily life, the fantasies of day dreamers, and the delusions of psychopaths. This paper is concerned with the diagnosis and proper handling of patients presenting for all these reasons and with the treatment of patients, who express themselves dissatisfied with the outcome of aesthetic surgery operations.

IS A SELECTION FOR CORRECTIVE RHINOPLASTY ADVISABLE?

NEUMAN, Z.

The patient's desire for a corrective rhinoplasty is the main reason for a surgical intervention. A well-adjusted patient in whom the desire for improvement has arisen spontaneously should be a good candidate and a grateful patient.

On the other hand, unfounded expectations should be tempered by the experienced surgeon, who should explore the field of psychological motivation.

A review of over 3000 patients during the years 1954-1971 has shown that over 90 % of the female patients have no psychological problem, but want to improve their looks according to accepted standards of beauty.

Every plastic surgeon should set his own standards of evaluation, because these vary according to environment, and are a result of the patient-doctor relationship, and the doctor's analytical potentialities.

The principles followed for refusing operation were as follows:

1. When patient voices an unusual urgency for operation.
2. When patient says: «If you do not perform the operation, I shall commit suicide.»
3. When patient shows fright or cries without obvious reason during the interview.
4. When patients are vague in the description of the change they expect.
5. Overembarrassed patients who demand a privacy such that no hospital can offer.
6. When patients show photographs of film-stars or have unrealistic expectations.
7. When patients who had operations elsewhere, come with minimal deformities, but blame the surgeon for a bad job.
8. When patients are over 45 and will adjust with difficulty to the new look.
9. When patients are influenced by their environment to undergo surgery and they themselves are undecided.
10. When patients demand guarantee for 100 % success.

With all this taken into consideration, there are borderline cases that should be operated on, but this should be the surgeon's careful decision.

A patient is presented to prove this point.

ANATOMY AND SURGICAL CONCLUSIONS CONCERNING THE AGING FACE

GONZALEZ-ULLOA, M.

Rhytidectomy, chemical or surgical abrasion, and recently, the restitution of adipose tissue have been the most employed procedures of the plastic surgeon to correct the problems of the aging face.

We have shown the need to perform rhytidectomy in a selective manner—that is, segmental, sectional or total—each related to the specific problem of the patient.

Abrasion has proven to be a method which, at least transitorily, thickens the skin, increases its briskness, helping to conceal the multiple small wrinkles intrinsic to the skin.

As for the restitution of volume due to adipose tissue absorption, we have described its methodology, materials, and controlled observations of the results.

However, none of the mentioned procedures, even if effectively performed, achieve a true appearance of youth when the facial gravitation phenomena have altered the position of the various commissures and affected the intrinsic laxness of the skin of the face.

To stimulate discussion on the need to create new and effective methods to correct many adjunct problems not solved by orthodox procedures will be the purpose of this participation on the panel on the Aging Face.

AGING DEFECTS: A REGIONAL APPROACH TO TREATMENT

GURDIN, M. M.

When a woman consults a surgeon regarding aging, she seeks a more youthful appearance. When a man consults for aging, generally he seeks relief from one or more defects incidental to aging, but is not compulsive about looking younger. He wants relief from these (to him) defects. A partial list of such defects encountered and treated by the author is:

1. Male pattern baldness.
2. Marked forehead wrinkling.
3. Deep vertical frown lines over the central forehead between the eyebrows.
4. Drooping eyebrows.
5. Redundant skin of the eyelids.
6. Herniated fat pads (baggy) of the eyelids.
7. «Crow's-feet» lateral to the eyes.
8. Deep alar-facial folds.
9. Submental skin and fat redundancy («turkey-gobbler» neck).
10. Redundancy (jowls) over the mandible.
11. Striae about the mouth.
12. Drooping nasal tip.

In some cases, the patient is best served by doing a facelift in combination with one or more of the procedures which will be described. In other instances, a facelift is absolutely contraindicated due to lack of hair, the patient's physical condition, age, or socioeconomic status. In other cases, facelifting would not correct the defect that is distressing the patient.

The above problems will be discussed in the panel.

VINAS, J. C. F.

In 1965 the author described an integral solution for the removal of stigmata of the aging forehead, based mainly on 3 anatomic observations.

- a) The existence of a deep, inextensible layer of tissue (muscle and aponeurosis) which occupies the frontal region and expands laterally.
- b) Existence of adhesions that fix the soft tissues of the supraorbital regions to the bony arches.
- c) Existence of two different types of wrinkles: dynamic (appear only with expression), permanent.

Anatomic variations of the forehead must be carefully evaluated in every case.

Objectives of treatment are elimination or correction of:

- a) Dynamic or permanent transverse wrinkles.
- b) Ptosis and/or downward slant of the eyebrows.
- c) Crow's-feet.
- d) Frown wrinkles.

Three Surgical Procedures are used, separately or together:

- 1) Temporal-frontal flap.
- 2) Butterfly wing technique.
- 3) Skin abrasion.

Temporal-frontal flap.—A transverse coronal incision is made and the flap is dissected as far down as required.

If the frown wrinkles are to be treated, 1 cm. of the medial and of each corrugator is excised.

For treatment of horizontal wrinkles, a transverse strip of the muscle-aponeurosis layer is excised, its lower limit 3 cm. over the eyebrows.

Butterfly wing technique.—Consists in the removal of skin either above the entire length of the eyebrows (rarely) or over the lateral ends (usually), and extending the excision outwards over the area of the crow's-feet.

Skin abrasion.—Indicated for treatment of permanent wrinkles, as a complement to frontal rhytidoplasty. It is performed as the last stage of the Frontal-Temporal flap procedure.

BLEPHAROPLASTY: SURGICAL TECHNIQUE

CASTAÑARES, S.

The purpose of this presentation is to consider some of the important physiological reasons, in addition to the purely aesthetic ones, and to give the precise surgical technique utilized during the last twenty years for the correction of «baggy eyelids».

Actually, there are times when the heavy and redundant upper eyelids fall like veritable curtains over the eyes, and the lower eyelids bulge in protruding masses, constituting a definite mechanical obstruction which obviously interferes with the normal fields of vision.

In the uppers lids, heavy folds of skin often rest over the lashes, and at times the lid and lashes are completely concealed, producing alteration in normal lid position, with dysfunction, eye strain, and fatigue.

SURGICAL TECHNIQUE

The precise step-by-step technique is given, starting with marking the areas of excision; removal of excessive skin; splitting the orbicularis muscle; opening of the individual fat compartments, removing the excessive fat; closure of the skin; dressings and postoperative care. Emphasis is placed on the careful technique for handling the lower lid to prevent ectropion.

SUMMARY

1. Physiological factors in baggy eyelids are discussed.
2. The steps in the surgical technique for correction of this condition are given in detail.
3. The patient's satisfaction and gratification due to the aesthetic and functional improvement obtained are discussed.

CHEMICAL PEELING

LITTON, C.

Over the past several years, chemical-face peeling has become an established procedure in the treatment of the aging face. This paper deals with the pharmacology, histopathology, and therapeutic uses of this technique.

The most widely used formula for chemical peels is a phenol compound, though others (such as trichloroacetic acid) have been used. Extensive toxicologic and pharmacologic studies of phenol have determined that there is a wide margin of safety in the usual amounts needed. Histopathology of the skin to which the formula is applied discloses keratolysis and keratocoagulation. Necrosis of the entire epidermis and into the papillary layer of the dermis occurs. Biopsies taken at three weeks after treatment disclose complete regeneration of the epidermis, and at the end of three months, there is evidence of changes of collagen in the stratum papillare. There are no remnants of cellular inflammatory reaction at this time however.

On the basis of twelve years experience, the author describes the indications, and contraindications, of chemosurgery. Rejuvenation of the tired, aged face as evidenced by fine wrinkling and loose skin is the area of prime consideration. Also, the technique is of great value in the improvement of post-acne scarring, and in the removal of some pigmentations. Surgical approaches are of greater value when there is redundant skin of the face and neck, particularly when there is a large amount of subcutaneous fat. Treatment of the neck is usually avoided.

The technique of application of the phenol compound is a straightforward one. However, patients are carefully screened as for an aesthetic surgery. Treatment of the full face is usually done in the hospital with analgesia, though limited areas can be accomplished in the office. Fine wrinkles about the mouth, eyelids and forehead are greatly improved, and a clean youthful appearance of the face results.

COMPLICATIONS IN AND TECHNIQUES FOR THE SURGICAL TREATMENT OF THE AGING FACE

FARINA R.

The main *complications* that may occur in rhytidectomy, some of them permanent, others temporary, are the following:

1. Haematoma (frontal, palpebral, cervical, facial).
2. Ecchymosis (palpebral, of the oral commissures, cervical and thoracic).
3. Paraesthesia and anaesthesia (auricular, facial and of the scalp).
4. Paraesia and palsy (frontal; oral; palpebral ptosis; lagophthalmus).
5. Persistent palpebral edema or lymphedema.
6. Excessive skin excision (ectropion; alopecia; dischromic scars).
7. Asymmetry of location of scars due to lack of preoperative markings
8. Asymmetry of the position of the eyebrows, of the earlobes and of the preauricular hair, and of the tragus.
9. Eye: There may be a risk of photophobia, micro-ulcers of the cornea, decrease of the ocular liquid, blindness.

The main *techniques* are:

1. The classic behind the hairline.
2. The technique (associated or combined) in front and behind the hairline.
3. In front of the hairline (in cases of wide forehead).

For the eyelids:

1. Divergent incisions.
2. Convergent incisions.
3. Muscular-cutaneous flaps.
4. Lateral para-palpebral Z-plasty in order to obtain a mongoloid effect.

In elder patients we give a connective muscular-periosteal external (malar) fixation stitch and dissect the skin from the orbicularis muscle in order to reduce the palpebral wrinkles.

Palpebral bags: we just perform two small incisions in the orbital septum (medially and laterally) and the emerging orbital fat is resected after clamping by means of «mosquito» forceps. When resecting the orbital fat, care must be taken not to damage the fibres of the elevator muscle of the upper lid.

ANATOMICAL FACTS CONCERNING MAMMAPLASTY: SURGICAL CONCLUSIONS

LEWIS, J. R.

A general discussion of the anatomy of the breast as related to methods of resection of the breast mass without interfering with the function of the breast tissue will be discussed. Methods of resections of the breast to reduce the massively enlarged breast while preserving the circulation and nerve supply to the essential portions of the breast, including nipple and areola, will be shown. Variations in the blood supply and nerve supply to the breast are inevitable and must be watched for at the time of surgery by carefully observing the circulation as the resection is carried out. Reasonable planning of the overlying skin flaps and the resection of the underlying breast mass permits an adequate reduction in the breast mass, allows for a pleasing contour, and an improved position of the breast on the chest wall, and accomplishes a youthful projection of the breast from the chest wall, while still maintaining a functional breast.

The effect on the breast tissue of a reduction mammoplasty by the free nipple transplant method is theorized, with cases to demonstrate the effect.

The reduction on the breast by the subcutaneous mastectomy can be carried out satisfactorily without sacrificing the blood supply to the overlying skin flaps, and often an adequate sensory nerve supply may be left.

Rarely is a knowledge of anatomy of a part more important than in the performance of a satisfactory reduction mammoplasty. The anatomy and the surgery are two very dependent parts of the same whole when it comes to surgery of this organ. Otherwise the surgery is fraught with many problems, and complications will be many and disheartening.

A FEW BASIC RULES CONCERNING PLASTIC SURGERY OF MAMMARY HYPERTROPHY

WINKLER, E.

It is not a certain method of operation, that is responsible for the aesthetic result of a breast reduction procedure. Each of the well-known procedures has its advantages and disadvantages and may yield good or poor aesthetic results. What is decisive for the result is the observance of certain principles.

For each case the technique that may yield an optimum result with the lowest possible risk and the smallest extension of scars should be selected, the basic requirements having of course to be fulfilled in each individual case (Electionism).

According to personal experience, the following methods may in principle be chosen, which an experienced surgeon will of course vary, blend and adapt to given circumstances without speaking of one's own procedure.

- 1) In very large hypertrophies the technique by Strömbeck is preferred.
- 2) Methods by which not more than 300 gr. of weight need to be reduced and which permit the glandular resection at various parts (Biesenberger, Gillies, and Mac Indoe, Ragnell, Pitanguy and others).
- 3) The technique according to Dufourmental used in correcting moderate hypertrophy and mamma pendulans yields good aesthetic results with slight extension of scars.

In principle the aesthetic result will depend upon the following criteria:

- 1) The distance from the nipple to the submammary sulcus must not exceed 7 cm.
- 2) The round shape of the areola must be retained and the mamilla must be sutured in entirely free of tension.
- 3) Immediately after the operation the nipple must look slightly downward.
- 4) The downward moving of the inferior pole (low gravity) immediately or later should be prevented.

It is not only the technique but the observance of certain principles in each technique and the experience of the surgeon that give the desired result. There is no ideal method for each deformity.

MAMMAPLASTY: PERSONAL TECHNIQUE

ARIE, G.

The author refers to the presentation of his original technique for reduction mammoplasty at the Latin-American Congress of Plastic Surgery in Havana (Cuba) in 1956 and to the publication in *Revista Latino-Americana de Cirugía Plástica*, January 1957, emphasizing that this technique has changed basically the principles considered valid before. After its presentation, several tactical modifications have been proposed by different authors without alteration of the basic principles established by the author.

This priority in the surgical treatment of breast hypertrophy and ptosis is based on the following principles:

- a) The physiology of the organ is absolutely respected.
- b) The technique is based on the pathology of the alterations present.
- c) No risk of complications.
- d) Simplicity.

The author emphasizes the main characteristics of his technique:

- a) No undermining.
- b) Obligatory fixation of the gland to the thoracic wall.
- c) No need for preoperative markings nor previous determination of the localization of the areola.

With regard to the problem of gigantomasty, he defends the principle of a two-stage operation, for which he uses the same technique.

The technique is therefore indicated for all cases.

The fundamental surgical steps are described and each stage discussed and substantiated. Finally some long-term results are presented and analyzed, as in the author's opinion an evaluation which is to be considered adequate should be made preferably 5 or more years after surgery.

REDUCTION MAMMAPLASTY: THE TWO PEDICLE PROCEDURE

STRÖMBECK, J. O.

The experience from a personal series of 580 patients operated on with the author's technique for reduction of the breast will be reviewed. The complication rate very much depends on the type of cases except for surgery. In very slim patients the complication rate is very close to zero, regardless of the size of the breasts.

Whereas in very fat patients the rate of glandular complications, e.g. fat necroses is about 10% and in very fat patients with a resection of more than 1 kg from one side, as much as 20 %.

In the preoperative planning it is important to make the skin flaps long enough to avoid undue skin tension. It is also wise to keep the distance areola-submammary groove as short as possible and to place the nipple fairly low to allow for a certain setting. In determining the new position of the nipple the submammary groove is a good guide. The definite shape of the breast should not be judged until one year after the operation.

Traction on the areolar regions should always be avoided in cases with short pedicles by cutting dermis of one of the two pedicles. The very fat breasts are the most difficult to fold. It could then be advisable to cut the lateral pedicle completely, relying only on a medial pedicle which in those cases should be made broader than usual.

Bulging of the lateral part of the breast should be avoided by making additional resection of tissue underneath the lateral skinflap.

MAMMAPLASTY BY THE LATERAL METHOD

DUFOURMENTEL, C.; MOULY, R.

The method which we propose is based upon two principles:

1. No, or very little subcutaneous undermining, because there is no plane between the glandular tissue and the overlying skin.
2. A single, straight, radial scar, running obliquely, externally and downwards, from the nipple, because it has always seemed to us to be much more rational to position the scar where the patients themselves prefer it.

Thus the medial aspect of each breast remains free of scarring. This seems important to us because this part of the feminine chest is the most frequently exposed.

The lateral method presents the following advantages:

Ease: because there is no dissection in vascular planes.

Safety: because the blood supply to the skin and the gland is well preserved, thus avoiding necrosis.

The moderate size of the scar: which, in the lower lateral quadrant of the breast, is rather unobtrusive.

A lasting result: since the gland has not been separated from its cutaneous sheath, to which it is closely adherent, and since there is no submammary scar which can act as a landmark for slight displacement.

Unspoiled bosom, the medial aspect of the breast being intact, thus preserving the intermammary vale.

REMODELING MAMMAPLASTY WITH SUPERFICIAL AND RETROMAMMARY DERMOPEXY

HINDERER, U.

A classification of the mammoplasty techniques according to their basic technical principles is given. The term «remodeling mammoplasties (with dermopexy)» assembles those techniques characterized by the plication of dermis upon dermis, with limited incisions of the dermis and preservation of the continuity of areola and gland, with which a reshaping of the breast with nipple transposition is obtained. Indications comprise all cases of mammoplasty except of hypoplasia without ptosis, and gigantomasty, and are characterized by their security with regard to blood supply and satisfactory aesthetic result.

The term «dermopexy» was introduced by Goulian (1970), the principle being also used by Schrudde. The technique of Strömbeck (1960) and that of the author for minor ptosis with small breasts presented in 1969, are considered pioneers of this principle.

Based on his previous technique, the author has developed the technique of «remodeling mammoplasty with superficial and retromammary dermopexy», presented in 1971 (XXI Congress of the Società Italiana di Chirurgia Plastica).

Technique for cases of normal or hypoplastic breasts: excision of the periareolar and subareolar epidermis, nipple transposition and periareolar suture (periareolar dermopexy); retromammary burying of two lower dermo-fat flaps, adjacent to the infraareolar dermis, which are attached to the pectoral fascia (retromammary dermopexy); due to the manner of rotation and fixation, as well as the plication and suture of the infraareolar dermis (infraareolar dermopexy), an angle of 60° between the infraareolar and the pectoral plane is obtained, which helps to maintain the shape of the breast after surgery, acting as a dermal pillar. Finally the skin excess at the submammary sulcus is excised and sutured.

In cases of hypertrophy, the glandular resection is performed at the deep surface and in cases of mammary hypoplasia, prostheses are inserted through an axillary approach.

For reconstruction after mastectomy the author prefers the subpectoral implantation of silastic prosthesis during the first stage followed by a secondary remodeling cutaneous mammoplasty.

TECHNICAL AND PSYCHOLOGICAL CONSIDERATIONS IN REDUCTION MAMMAPLASTY

TAMERIN, J. A.

The technical aspects of reduction mammoplasty have been well-documented and researched. In general, the small ptotic breast may be improved by skin excision alone. Folding the breast and subcutaneous tissue into the reduced skin envelope may also be accomplished in a number of satisfactory fashions. Reduction of the volume of the breast can be done: 1) with the transposition of the nipple, 2) with transplantation of the nipple. The author believes that the Lexer-Kraske breast reduction with transposition of the breast is the precursor of modern breast reduction. He feels that this technique for the moderate enlargement is preferable to the more drastic procedures that should be reserved for the more marked hypertrophies of the breast. For these, the Strömbeck technique inaugurated a significant contribution in the safe transposition of the nipple based on a more accurate conception of the blood supply of the nipple than previous authors had realized. However, there are many cases where the excision of the core of breast and subcutaneous tissue from above the nipple is undesirable. One can modulate by the appropriate use of the Lexer-Kraske technique, the Strömbeck technique and obtain a much higher percentage of satisfactory results than is possible by the insistence on the use of one technique alone.

Similarly, the insistence on the use of a nipple transposition technique in the cases of marked hypertrophy bordering on gigantomastia is unwise, since the Jerome P. Webster technique of free nipple transplantation breast reduction is so effective in achieving an artistic and psychologically satisfactory result. This technique has, unfortunately, never been published by Webster but has been used by his pupils for over twenty-five years, and is surprisingly similar to the Strömbeck technique in many respects.

Lastly, the psychological aspects of breast reduction must be thoroughly respected. Improper choice of patient and procedure can be disastrous. Also, a careful informing of patients concerning not only shape, scars and possible lectionation is absolutely necessary, but the patient's feelings with respect to erotic sensation and body image alteration should be thoroughly studied.

COMPLICATIONS OF MAMMAPLASTIES

CARONNI, E. P.

Like all surgical treatments, mammoplasty operations as well may lead to complications that may be classified under three groups:

1. **Functional complications:** We shall first of all examine all the different techniques we have at our disposal to perform with satisfaction a mammoplasty operation. These techniques, rapidly examined, enable us to execute a mammoplasty operation according to criteria of functionality; either they suggest to us the interruption of the continuity of the galactoforous ducts or of the areola free transplantation, thus interrupting the functional unity of the gland. We shall consider later on whether or not the scar residuals of the so-called physiological techniques lead to an inefficiency of the gland even though it is left integrally complete during the surgery.

2. **Surgical complications proper:**

a) The haemorrhage may be the most frequent complication occurring, depending on the different methods used.

b) The suppuration, not very frequent, may sometimes be considered a late result of the haemorrhage due to the bacterial organization of a haematoma.

c) The necrosis, which is due to a surgical error, or to the late result of a haematoma, may involve either the areola only or small or large parts of the tissue covering the new mamma and it has a little or large incidence according to the technique that has been used.

3. **Aesthetical complications:** They depend upon the technique and may involve the position of the nipples, their orientation, the size of the new breast, the kind and extension of the residual scars.

In summary, we may say that peculiar complications of certain techniques exist, and sometimes they appear because the features of a mamma were not carefully examined before the operation, or because a technique not suitable to the specific case was applied.

As a conclusion the author gives some suggestions which, in his opinion, may be useful for choosing the most appropriate method, with the least risk of complications, according to the different anatomic situations that are to be considered when the surgeon is planning a mammoplasty intervention.

RHINOPLASTY - A NEW TECHNICAL CONCEPT

SERSON, D.

It is very important for the surgeon, who is going to perform a rhinoplasty, to keep in mind some pattern lines which constitute a harmonious nose, thus assuring a true comprehension of his sculpturing aim.

The author presents a new aesthetic rhinoplastic concept, considering the nose as a unity, composed of anatomical interdependent structures, that require a chronological procedure be followed.

The treatment of one of these structures induces and orients the correction of the next one.

The author stresses the importance of some sculpturing details that must be maintained at the tip of the nose, reproducing the beautiful natural nose.

This is achieved by the proposed technique, which always leaves the lower rim of the alar cartilage untouched.

According to the author's experience, the shortening of the nose is achieved only by surgical intervention on the alar cartilages.

In his series of more than 1.000 noses, the border of the septum was not touched in order to shorten the nose, as recommended by the classical methods.

With this technique only the upper third of the columella, that is only the tip is raised; in this way a hidden columella, pinching and other surgical complications are completely avoided.

AESTHETIC RHINOPLASTY IN CASES OF FUNCTIONAL DISORDERS

MEYER, R.

Not only external deformities or aesthetic imperfections of the nose but also disturbances of the nasal function represent an indication for rhinoplasty, which is then combined with septal correction in one stage. If we encounter major septal deformities, we have to perform some elaborate resections of angulations and the lamina quadrangularis has to be visualised at the dorsum and through the transfixion incision as well. Usually it is better to carry out the elevation of the mucoperichondrium through a separate incision. At the level of a crooked antero-inferior edge of the septum, mattress sutures with or without bilateral support of plastic sheets are used for contention after a «swinging door» procedure. We correct the septum first, as is usually done, but after a previous bilateral intercartilagineous incision, skin elevation, transfixion incision and eventual hump removal. The upper lateral cartilage is partially resected in an extramucous manner. If the bony part of the nose is deviated as well, we extend the skin elevation from the dorsum laterally further than the lateral osteotomy line. Then we perform this osteotomy by means of saw and chisel and we «infracture» at the transversal osteotomy line. We proceed in this way in all cases of difficult bony framework while we practise a limited skin elevation, blind lateral osteotomy and outfracturing in all cases of simple bone work. So we always adapt our procedures to the deformity and to the difficulty of the correction both for the bone as well as for the tip of the nose. We model the lower cartilage by means of the luxation method through a marginal incision in difficult cases, through the intracartilaginous incision in easier cases and by means of the eversion method in easy tips. In order to produce a break at the columella we insert pieces of alar cartilage into a superficial pocket in the anterior third of the columella. Very often we sculpture the nostril by trimming the edge or by appropriate resections at its lateral and even medial base.

SUBPERIOSTAL OSTEOTOMY FOR NARROWING THE NOSE

SCHRUDDE, J.

The subperiosteal osteotomy, as described by us in 1969, can be combined with any other procedure in the cartilagenous region of the nose. In the osseous part we proceed as follows: the periosteum on the edge of the apertura periformis is slit and first lifted off the outer and then from the inner surface of the processus frontalis. Into this pocket we insert the rhinotome, as developed by Olivari and Schrudde, which has a horizontal as well as a transversal edge. With this instrument the bone is cut in the desired places. The bone fragment lies now within the rhinotome. This enables the reconstruction of noses which have been deformed by trauma, and which necessitate lifting or lateral corrections. For aesthetic corrective nose interventions the osteotomy must be completed by an additional step if no reduction of the nasal dorsal edge is intended. If this step is taken, then the dorsal cut is defined and the mobility of the fragment is given by the application of the rhinotome. If no reduction of the dorsal edge is performed, an additional cut with chisel or saw becomes necessary in the area of the Sutura naso-maxillaris. The conservation of the periosteum supports the fragment in its new position and seems to influence favourably the healing process around the osteotomy. Retrograde movements of the fragment, as sometimes observed before, were not observed with this method. A prolonged retention appears unnecessary.

Since first describing this method, our experiences were confirmingly positive. We extended the range of instruments, by two additional rhinotomes with varying curves, which allow for a greater variation of technique.

FRACTURES IN RHINOPLASTY

MIR Y MIR, L.

The author writes briefly regarding the 1st and 2nd fractures so as to present his ideas and conclusions in regard to the 3rd fracture (lateral fracture).

He fractures by means of a chisel and has never used a saw.

1st Fracture. The extirpation of the hump is accomplished, simultaneously extracting cartilage and bone in one piece. It is adapted in each case according to the anthropometric requirements and may be complemented by the extraction of a small portion of frontal glabella «jumping» over the bone bridge of the nasal radix.

2nd Fracture. Sagittal, to free the nasal radix from its frontal continuity.

The 3rd fracture, or lateral, is always effected externally with a 2 or 4 mm. chisel depending on the case. He believes that no other technique can surpass the achievement of the two essential requirements in fracturing:

- a) It must be effected as laterally as possible.
- b) It must reach as high or frontally as possible.

The fractures accomplished by means of a chisel do not leave residue (bone chips) and the field is much wider and reachable.

All this is easily achieved with the external fracture and usually one knock with the chisel is enough if it is given at the right point.

The author insists on the study of the flying buttresses (arbotantes) of the architectural base of the nose. The two bone curves which form the nasal architecture on the anterior plane of the face, intersect precisely at one point, which concentrates the firm bony resistance of the region. These two buttresses constitute, at the point where they cross, the key to the problem. If the 3 mm. chisel, situated horizontally and parallel to the anterior plane of the face, is placed exactly on this point, only one knock on the chisel is needed to break this resistance, and a linear and complete fracture is obtained along the length of the whole base of the nasal wall. Consequently, the narrowing of the nasal pyramid is obtained easily.

ADVERSE RESULTS AND COMPLICATIONS IN RHINOPLASTY

MARINO, H.

Given time and space limitations, the author reports only on some aspects of this vast problem in which he is able to contribute personal observations or ideas.

Among postoperative complications hemorrhage can be troublesome and, at times, difficult to suppress. Its continuation, once blood-clotting defects are treated, can be ascribed to the sections of orbital perforating branches of the ethmoidal arteries (Goldenberg). In extreme cases an antero-posterior packing could be the only way to stop the bleeding. A convenient means to keep the tension on the string holding the posterior packing without injuring the alar border is described.

Examples of inflammatory reactions on the upper part of the lateral section of the nasal bones and their treatment are discussed.

Mild secondary nasal obstruction caused by excessive removal of mucosa can be easily dealt with by a convenient redistribution of the remaining lining. Serious obstruction of similar origin has been treated by covering the defect with a skin graft, preventing its secondary retraction by use of a convenient stent over a prolonged period of time. A mucosal flap from the upper lip, introduced by a vestibular approach, will provide an excellent material in such circumstances (and also for repairing septal defects), avoiding the troublesome moulding of the cavity.

Extended resection of lining and alar cartilages can also cause a collapse of the alae with an unsightly infold bordering the nasal apex. Its successful correction has been achieved by entering the area of the defect through a marginal incision to create a pocket between outer and inner alar layers. There a thin-shaped piece of costal or conchal cartilage is inserted to restore the curvature of the arch. In extreme cases this had to be preceded by a previous repair of the lining with a mucosal flap as described above.

BONE GRAFT: ULTIMATE PROCEDURE OF SECONDARY RHINOPLASTY

TESSIER, P.

Some aesthetic rhinoplasties usually done by unqualified surgeons result in an ugly appearance: distorted or depressed nasal bridge, sinking of the septum, collapse of the alae, retrusion of the tip, retracted mucosa, obstruction of the nostrils.

These conditions do not always allow ordinary nasal revision, nor implantation of cartilage or Silastic support which would risk being extruded. So, bone graft of the nasal bridge is a safe procedure, even in the worst conditions described. The only inconvenience is its rigidity.

The graft may be either iliac or rib. The conditions for a fast «take» are:

- 1.—Wide submucosal dissection.
- 2.—Wide subperiosteal dissection.
- 3.—Scraping of the bone remnants.
- 4.—Deep resection and cleaning of the frontonasal angle.
- 5.—Wide fitting between the graft and the frontonasal framework.
- 6.—Graft long enough to come down to the columella, under the domes which are sutured together.
- 7.—Support of the distal end of the graft by an auxiliary bone graft pegged into the maxillary spine.
- 8.—Effort must be made for lengthening these too short noses.
- 9.—Twin drains inside each nostril, and wide plaster for two weeks.

Sixty cases have been operated on according to this technique with 2 failures. Some cases have been seen after 20 years without noticeable bone resorption. Three cases got fractures of the graft; nailing of the two fragments resulted in complete consolidation confirmed by the removing of the nail after two months.

RHINOPLASTY IN THE THICK SKIN NOSE

ORTIZ-MONASTERIO, F.

The problem presented for corrective rhinoplasty in the cases with extremely thick skin are discussed and the relative thickness of the skin coverage of different areas of the nose is presented.

A series of patients treated by shaving and/or dermabrasion simultaneous with the rhinoplasty or performed as a secondary procedure are studied. Bone-grafting and selective skin excision were done in some of them.

The results are analyzed in a long term follow-up in relation to aesthetic effect, skin texture and coloration.

TREATMENT OF PROMINENT EARS

MUSTARDÉ, J. C.

Prominence of ears is basically due either to failure of the auricular cartilage to form an antihelix fold or the formation of an antihelix fold too far from the auriculo-cephalic sulcus with formation of an excessively deep concha.

The former condition produces the most prominent type of ear, but is the simplest to correct: the cartilage of the ear always being sufficiently pliable to allow it to be moulded to produce an antihelix which is held permanently in position by 3 or 4 nonabsorbable mattress sutures buried beneath the skin.

In the second type of prominent ear it is necessary to remove all connective tissue and muscle from the concave surface of the existing antihelix fold. It will then be pliable enough to allow it to be rolled in such a way as to obliterate the old fold and produce a new antihelix fold which will use up some of the excessively deep concha, and which is held permanently by nonabsorbable sutures. The author has always found it possible to roll the cartilage in this fashion, provided the posterior surface of the cartilage at the site of the existing fold has been completely denuded.

ANSIFORM EAR CORRECTION

PITANGUY, I.

The augmentation of the cephalo-auricular and scaphalo-conchal angles, generally associated with the erasure of the antihelix defines a congenital auricular dysmorphism called «bat ears», that by its strange aspect creates innumerable complexes in its bearers, making their social life difficult.

Our technique is based upon the construction of a cartilage «island» in order to replace or reconstruct the antihelix as well as to diminish the scaphoid fossa, by the forward projection of the cartilage segment which constitutes the «island».

The forward projection of the cartilage made in accordance with the line previously created and which will replace the future antihelix, does not represent a pleating of the cartilage in continuity with its spring, but is a real «island» which is completely free, making any recurrence more difficult, and dismissing transfixing stitches, prolonged immobilizations, often uncomfortable during the postoperative stage, especially with adult patients of the male sex.

The reconstruction of the antihelix spontaneously corrects the scaphaloconchal angle, diminishing at the same time the amplitude of the concha. The correction of the cephalo-auricular angle is obtained through the immobilization of the concha after the retroauricular cutaneous resection performed in a subdermic plane in order to maintain a protective bed. This resection is often delineated in such a way as to provide a more accoladed ear to the head in the proximal aspect, rather than to the distal one.

CORRECTION OF PROMINENT EARS, SURGICAL TECHNIQUES:
A REVIEW

LEWIN, M.

Cutaneous maneuvers (excision of fragments of skin), play mostly a historical role in the correction of these ear deformities, except for repositioning of the ear lobe, for which some modification of the W-excision is practiced by most surgeons.

Emphasis in the repositioning of the protruding ear is placed on the reshaping of the auricular cartilage. Recommended procedures can be divided into the following categories:

1. The reshaping of the auricular cartilage is done with sutures only, without altering the cartilage.
2. The cartilage is altered either by thinning the scapha, or multiple incisions or excision of fragments (mostly in line with the inferior crus of antihelix and along the conchal wall).

There are innumerable variations and combinations of these two principles. These procedures are performed from the medial surface of the auricle. Most surgeons emphasize that the upper, middle and lower thirds of the auricle require different management.

The deformity is evaluated as to whether the protrusion is primarily of the upper pole, or the concha is too large, or the antihelix is absent, etc. and the procedure is adapted to the requirements of the case.

A third category of procedures avoids wide exposure on the medial surface and relies on minimal incisions, mostly on the lateral surface of the ear, permitting the introduction of sutures which attach the ear to the mastoid area.

The poor results can be attributed to inadequate correction or recurrence of protrusion of the entire ear or one of its thirds, an unnatural sharpness of the antihelix, wrong scapho-conchal relationship, or displacement of the lobe.

Keloidal scarring on the medial auricular surface is another complication.

PROMINENT EARS

SPINA, V.

Many techniques exist for the surgical correction of prominent ears, all having the same purpose of reducing the frontal projection of the pavilion even though there are others with some details for decreasing other associated morphological deformities. There are three fundamental clinical varieties of the deformity:

a) Lop ears in which the deformity is caused only by the increase of the concha-scapal angle (most common).

b) Lop ears in which the projection originates only from the hypertrophy of the concha.

c) Variations of a and b.

The techniques vary according to the deformities described above.

In general the techniques may be summarized as those which model the antihelix, reducing the concha-scapal angle without operating on the cartilaginous structure, and those using incisions of the skeleton for contouring.

The most frequent complications are the following:

a) Morphological changes of the cephalo-conchal quadrilaterus when the approach is over the retro-auricular sulcus (the incision should be done in the sulcus of the antihelix).

b) Hematoma - this should be drained as soon as possible and its formation prevented by using a pressure dressing.

c) Keloid - it should be resected and irradiated.

d) Asymmetry - in which one pavilion differs from the other with relation to the cephalo-conchal angle.

e) Postoperative disappearance of the prominences of the antihelix.

f) «Telephone» - like pavilion in which the superior and inferior poles of the external ear are projected frontally and the central part is glued to the mastoid.

REDUCTION OF THE EAR LOBE DURING CORRECTION OF THE PROTRUDING EAR

LOEB, R.

The author's experience indicates that the ear lobe frequently needs to be reduced while correcting the protruding ears. These hypertrophies of the lobe can be due to hereditary factors linked to a family characteristic, or to growth development.

The ear lobe consists of soft tissues without interposition of cartilage, while it is variable in size and can be quadrangular, triangular, semi-circular or semi-elliptical.

The position of the lobe may be influenced by the cartilaginous tissue of the pavilion, and this occurs, among other circumstances, when the tail of the helix turns the lobe towards the side, thus increasing in its transversal sense.

The anatomical limits of the auricular lobe are of utmost importance for the surgical treatment of its hypertrophy:

a) in its upper limit: the supra-lobular sulcus;

b) in its anterior limit: its implantation in the auricular region. The most inferior limit of this implantation is called «otobasion inferius», and the upper limit ends at the anterior extremity of the incisura intertragica.

The technique we employ in our cases is as follows:

1. We free the lobe from its implantation in the face, from otobasion inferius until the anterior extremity of the incisura intertragica. In the adult this distance is approximately 2 cm.

2. Departing from the anterior extremity of the supra lobular sulcus, the resection of a diagonal full thickness portion of the lobe is performed in order to reduce the lobe's width.

3. Resection of a triangular full, thickness portion of the lobe is also done to reduce the lobe's height.

4. Suture is performed.

IN THE TREATMENT COMPLICATIONS OF PROMINENT EARS

DAVIS, J.

The author has practised different types of surgery, and seen the result of his own and other surgeon's treatment for prominent ears, over 25 years experience. The types of surgery, and their results, are considered. None is perfect, and all have had complications. These complications vary with the surgical techniques that were used, the healing potential of the patients, and postoperative accidents. Each of these situations is analysed.

All full-thickness cartilage incisions leave a ridge on the anterior surface that is clearly visible, and denotes «operated ears». This includes cross-hatching, parallel longitudinal antihelical incisions, or island cartilage roll. Lack of appreciation of the prominence can produce abnormal set-back, with residual jutting of the helical dome and the lobule, as «telephone ears». Excess skin excision with mastoid fixation leaves a sequel of postauricular adherence. Postauricular approach and untidy dissection can destroy sensory nerves, and a helical dome anesthesia remains. Defective healing may give rise to keloids. Conchal excision produces conchal creases.

Suture material has shown considerable intolerance, and each type of suture material reacts differently. Silk, cotton, nylon, and wire are considered, both the single and multi-filament varieties. Some have even produced inflammatory reactions severe enough to create chronic chondritis.

The author presents solutions for these problems, surgical, radiotherapeutic and medical. He also proposes fundamental rules to avoid them.

And he concludes that the most important part of the treatment of prominent ear, is not only to reduce the prominence but to make well-proportioned ears that will fit the face of the particular patient.

THE TEMPORAL RHYTIDECTOMY INCISION, ADVANTAGES, DISADVANTAGES AND PITFALLS

MURRAY, R. D.

The temporal incision has been advocated primarily by Mario González-Ulloa. The advantages of this method include a better way of obliterating the nasolabial folds and the jowels, because one is better able to produce the upward and outward motion so necessary to obliterate the effects of age. It leaves a visible scar, as well as there being danger to the branches of the facial nerve supplying the frontalis muscle. These nerves run superficial to the temporal fascia and can be very easily damaged by a deep incision because they are to be found quite close to the orbit. The dissection in this area needs to be very superficial to avoid damaging them.

SEGMENTARY GAUGING OF THE SKIN AND SCALP EXCISIONS DURING FACIAL RHYTIDOPLASTIES

LOEB, R.

In order to measure correctly the tension to be applied in the suture line during rhytidoplasties, the author follows an operative sequence essentially based on a personal technique shown in a film he presented during the III Congress of the International Confederation of Plastic Surgeons, in Washington, 1933.

This technique consists of gauging the amount of skin and scalp to be resected through the use of perpendicular incisions performed in the undermined cervico-facial flaps. Rectangular portions of skin and scalps are then excised according to the length of the above-mentioned perpendicular incisions.

As a complement to the above-mentioned technique, the author actually uses some anthropometric points of the face and auricle, for a better tailoring of the ear lobe. These anthropometric points are otobasion inferius and the lowest point of the intertragal notch. This last step is most important in order to avoid bad positioning of the reinserted ear lobe.

It is the author's experience that by using the segmentary gauging, the possibilities of bad scarring or necrosis are greatly reduced because the areas submitted to traction receive an adequate tension.

TECHNIQUE

A proper demarcation of the incision line is performed. After elevating the cervico-facial flaps, the amount of skin and scalp to be resected is gauged and some stitches are placed in the temporal region immediately above the ear. In the retroauricular area, segmentary incisions are then performed.

The excess skin and scalp is resected in the fronto-temporal, and occipito-mastoid regions. The ideal position for the ear lobe implantation is accurately searched, using Otobasion Inferius and the lower limit of the intertragal notch as reference points. Final suture is performed. This segmentary technique is also frequently used for the correction of forehead wrinkles.

FACE LIFTING: RAISING OF THE EYEBROW BY MEANS OF A LONG CURVED TEMPORO-PARIETAL INCISION

LEMOS, P.

The author presents some cases of face-liftings in which the raising of the eyebrow and the correction of crow's-feet, are obtained by elongating the temporal incision of the normal face-lifting, in a long curved line, that finishes near the hair-line a point corresponding to the external third of the scalp. So the incision leaves the preauricular sulcus, goes back for two centimeters more or less, then moves up in a vertical direction for three or four centimeters, and from this point on curves smoothly to the point mentioned above. The rest of the incision is done according to the normal rules.

The undermining is carried down to the fascia, from the emergence of the temporosuperficial vessels and goes bluntly elevating all the region comprised by the line of incision, stopping one centimeter off the eyebrow and the external canthus of the eye, more or less. The rest of the undermining is made superficially as usual. After the completion of the undermining, the skin is lifted up and backwards without exaggeration, and some stitches are tied at the points of greatest tension. These points are located one centimeter above the ear insertion and three and five centimeters up. Then the large amount of scalp above is stretched nearly vertically, raising the frontolateral skin and the eyebrow and bettering the crow's-feet. The excess is cut and some stitches are tied. The suture is then completed, and the rest of the operation continues its normal run.

The author has obtained satisfactory results with this technique. To his mind the external incisions over the eyebrows to lift it are restricted to the very severe cases.

DIRECTION OF TRACTIONS IN RHYTIDOPLASTY

CANSANÇAO, A.; PITANGUY, I.

The authors analyze various types of rhytidoplasty, emphasizing the importance of the uniform traction, in the direction of the tragus to the tubercle of Darwin, in order to obtain a natural-looking face.

They present the methods idealized by the senior author, as the location and fixation of the temporo-frontal flap before its resection, in order to diminish the elevation of the pilose implantation.

The compensation that is made forward is not achieved by the central traction before the fixation of the temporo-frontal flap, thus preventing its over-correction and giving a natural aspect to the face. Attention is called to the direction of the whole traction, including the eyes that should be uniform to prevent any impression of an operated face.

These considerations imply contraindication of the pure temporal rhytidoplasty of «mini-lift», considered inefficient and, due to the pilose implantation, hampers future operations.

SILASTIC-SHEET RHYTIDOPLASTY FOR FRONTAL & GLABELLAR WRINKLES

SHANOFF, L. B.; AZZATO, N. M.

Many operations, some of them quite radical, have been devised for the ablation of deep rhytids in the frontal and glabellar areas. We have, as have others, found most of these to be unsatisfactory, for while affording a beneficial early result the long term appearance is all too often disappointing. The common denominator of these failures is the reattachment of the separated muscles to the skin, with the eventual reformation of the deep rhytids.

Our new approach involves the subcutaneous implantation of silastic sheeting into the forehead, the glabella or both, thereby permanently separating the facial muscles from their cutaneous attachments. This easy technique may be performed alone or in combination with more extensive facial rejuvenation procedures. The operation, postoperative maintenance and potential complications are described.

A TREND OF NEW OPERATIONS TO IMPROVE THE RESULTS OF RHYTIDECTOMY

GONZALEZ-ULLOA, M.

Excellent results are obtained with rhytidectomy skin abrasion, either chemical or mechanical, and reposition of lost adipose tissue either as single or combined procedures as indicated in the first five decades of life when there is still no marked absorption of the adipose tissue; when neither serious distention nor intrinsic laxness of the skin has occurred. But when there is a severe absorption of adipose tissue, or the skin is markedly lax and thin, and the commissures have descended noticeably, the procedures mentioned, even when accomplished effectively, do not help to restore the patient youthful appearance.

Through a radiological study already reported on, observation of the changes suffered in the superficial anatomy of the face was carried out.

This study showed that the commissures of the face descend noticeably with age; that the skin drops well below the level at youth; that the supportive structures suffer alterations that affect the normal architecture of the face, causing —per se— the senile aspect of the face.

These changes can be summarized in the following manner: (1) changes in the position of the eyebrows; (2) alterations in the position of the palpebral commissures; (3) descent of both nasal tip and columella; (4) descent of the skin at zygomatic malar support level; (5) marked descent of the upper lip with gravitation of the labial commissure below its normal place; (6) changes in the shape of the upper and lower lips; (7) descent and volume diminution of the chin, as well as (8) important modifications in the structures of the neck together with cutaneous descent which cannot be corrected through simple rhytidectomy.

In the written paper, a synthesized account of the procedures that can be used to correct these problems is done. In certain cases, procedures already known solve the problem satisfactorily; in others, it is necessary to start trying new procedures to correct the problem of some of the facial segments. To describe the planning of these procedures is the purpose of this paper.

THE MODIFIED DERMOPEXY-RHYTIDECTOMY OF RISH

MEYER, R.

One year ago I discussed with Dr. Rish his innovation in face-lift surgery and suggested some further modifications. In patients between 30 and 50 years of age, a complete rhytidectomy is not always necessary and we can limit the intervention to a blunt dissection only in the neck and eventually also in the temporal region. We perform the upward and backward displacement of the skin of the cheek only by dermopexy of the de-epithelised preauricular area. Only the skin of the tragus is removed in its full thickness in order to obtain a skin flap of correspondently full thickness which can be outlined and dissected at the anterior border of the de-epithelised area. Since in this flap there is no traction at all, the tragus will not be deformed. We avoid placing the incision in the preauricular fold because the dermopexy method easily increases this fold. In the postauricular area we sometimes carry the incision high up in a double-waved curve ending in the hair-bearing skin and forming the Berry's «postauricular flap».

THE LIFTING OF THE UPPER LIP

DUARTE CARDOSO, A.

The following changes can appear in the upper lip of aging people: excess of skin with increasing height of the lip concealing the vermillion, and vertical wrinkles.

To correct this aspect of aging we found that the literature indicates excising a band of skin just above the mucous edge, and in more severe cases an additional skin excision at the midline.

The majority of experts prefer only to use dermabrasion. In addition, a method for treating deep verticle wrinkles by means of temporary subdermal implantation of Silicone-sheets has been described by Hinderer.

We found an alternative to the problem, excising skin from the upper part of the lip, close to the nasal vestibule.

The area of excised tissue is narrower in the midline next to columella, widens laterally at the level of the nostrils and diminishes progressively, ending at the nasal sulcus on both sides. A wedge excision is performed including skin, subcutaneous tissue and muscle. No extensive undermining is done. With the suture, the height of the lip is reduced and the vermillion more exposed. Greater stretching at the level of the nostrils results in accentuation of the Cupid's bow.

Dermabrasion may be added to the procedure.

The resulting scar is unnoticeable in a few days.

THE FUNCTIONAL DIFFERENCES OF THE SMILE

RUBIN, L. R.

The study of hundreds of smiles in normal individuals has shown varying shapes apparently caused by different muscular actions. The author has dissected the lips of six cadavers. The muscles were traced from their origins to their insertions. The results were illuminating: **CONTRARY TO THE USUAL ANATOMICAL DESCRIPTION GIVEN EVEN IN SPECIALIZED TEXTBOOKS, IT WAS FOUND IN ALL CASES THAT:**

Lip elevators sent their fibers deep through the orbicularis oris to attach to the inferior portions of the vermillion.

The relative strength of the contracture of the quadratis labii superior is the prime variant in lip-shaping. Thus, a smile is the sum contracture of the elevators and depressors of the lips and their lateral angles. The relative muscular strength of different components alters the smile in individuals.

There are secondary factors altering the shape of the normal smile:

1. Congenitally long or short lip.
2. The bony length of the face (superior and inferior measurements).
3. Retrusion or projection of the maxilla.
4. Retrusion or projection of the teeth.
5. Deformities of the mandible.

The study of smiles has enabled the author to classify the normal expression into three categories:

A. «The Canine Exposure Smile» caused by excessive contracture of the elevator labii superior (Gloria Swanson, May West).

B. «The Corner of the Mouth Smile» caused by the dominance of the elevators of the corners of the mouth (Mona Lisa).

C. «The Full Denture Smile» caused by the equal pull of the elevators and depressors of the lower as well as the upper lips (Lena Horne).

It becomes apparent from the study of the normal smile that the correction of the unilateral facial paralysis must follow the direction of normal muscular contractors.

PALPEBRO-JUGAL APPROACH IN CORRECTIVE SURGERY OF THE LOWER EYELIDS

MOREL-FATIO, D.; LALARDRIE, J. P.

The various clinical aspects of «baggy eyelids» correspond to different anatomical conditions. No «standard operation», as satisfactory as it could be, can fit all the types, and the operative procedure must be appropriate to the specific deformities which have to be cured.

In aged people, mainly in male patients whose skin has a great laxity, there is sometimes a true bag which predominates at the lower border of the lid, the bottom of this pouch hanging in front of the palpebro-jugal fold, more or less concealing the junction between the thin skin of the lid and the thick teguments of the cheek.

In these conditions, a classic blepharoplasty, with an incision along the ciliary border, would not allow the deformity to be rubbed out or this should only be made possible if an excessive upwards traction is applied to the upper flap, leading to an ectropion.

In such cases, we leave the upper part of the lower lid untouched, and we incise along the fold parting the lid and the cheek.

The palpebral flap is raised in order to free it from its attachments to the orbicularis muscle and the excess fat is removed. Then the extra skin of the lid corresponding to the bottom of the pocket is excised according to a crescent excision and the free edges are approximated with fine interrupted sutures between the thin teguments of the eyelid and the thick skin of the cheek.

The only objection to this method, which is very safe and efficient, is that one has to suture together two skins of unequal thickness and slightly different in colour, the lid skin being generally a little darker than the teguments of the cheek.

THE TREATMENT OF BAGGY EYELIDS THROUGH THE CONJUNCTIVAL ROUTE IN YOUNG PATIENTS

TESSIER, P.

Baggy eyelids are not the privilege of the «forties». They often occur in patients less than 20 who are bored by this small but real disfigurement which makes them look tired.

Since skin resection is useless for these patients, we use the technique described by Bourguet in 1920:

- conjunctival incision between the tarsus and the lower fornix,
- dissection behind the orbital septum,
- resection of the fat as usual in the three «loges».

Care must be taken not to damage the inferior oblique muscle. Desmarres and Mawas retractors are very helpful when hemostasis is necessary.

Main advantages noticed during the last 20 years are:

- outpatient procedure,
- absence of ecchymosis,
- very slight oedema,
- complete absence of scar on the skin,
- extremely fast recovery of normal appearance.

CORRECTION OF CROW'S-FEET DURING FACE-LIFTINGS

ELBAZ, J. S.

In the classical face-lifting, the upward and backward traction of the teguments actually emphasize the external palpebral wrinkles, which —if they are numerous— produce crow's-feet.

The author reports some twenty cases, in which the employed method was a procedure of double V-resection on the scalp, the purpose of which is to smoothe out the skin of the palpebral area. He recommends to associate systematically this double incision with the classical incision of face-lifting on the scalp.

COSMETIC REHABILITATION AFTER RHYTIDECTOMY

JENNY, H.

If a plastic surgeon performs a lot of aesthetic facial surgery, it is a well-know fact that women, after rhytidectomy, often succumb to various degrees of depression. In seventy-five consecutive rhytidectomies, the patients have been carefully studied to determine the factors involved in such a depression. It was found that the day of removal of the dressing coincides with desolation, disappointment and increasing depression. The face is swollen and so are the eyelids. The hair is plastered with dried blood, and the patients are unable to brush it, or to groom their face.

A special cosmetic room was created with all the professional equipment necessary to allow professional cleansing and styling of the hair, and proper illumination for the application of makeup. Thus, on the third postoperative day all the dressings are removed and so are the upper and lower eyelid sutures. At this point, the entire scalp is carefully washed with pHiso Hex and rinsed with hair conditioner. The hair is then styled in a manner to hide the remaining sutures, and with a special makeup, the few remaining ecchymoses are covered. Within two hours the patient is helped to overcome the first shock and is immediately given an optimistic outlook for the next few weeks.

This early cosmetic rehabilitation has reduced postoperative depression and nearly eliminated the need for postoperative pain medication and mood elevators after the third day. Some of the more courageous patients go out to dinner or attend public functions before the tenth day, at which time the remaining scalp sutures are removed and the hair and face treated.

The cosmetologist is to the aesthetic plastic surgeon what the physical therapist is to the orthopedic surgeon and neurosurgeon.

FACIAL RHYTIDECTOMY: TECHNIQUE AND USE OF A TENSIO METER FOR DETECTING HEMATOMAS

CARRATO, R. H.

Aesthetic surgery of the face may include, separately or in conjunction, the following items: face lift, blepharoplasty, surgery of the forehead wrinkles, correction of double chin and dermo-abrasion. The chemical planning should never be used in conjunction with a face lift. This surgery is usually performed under general anesthesia in conjunction with subcutaneous infiltration of xylocaine with epinephrine 1 : 100,000.

For rhytidectomy, we use the line of incision well back in the hair line with sufficient hair left anteriorly, and at the preauricular region the incision follows the inner border of the tragus. The correction of the wrinkles of the forehead is made with a selective resection of muscular fibres previously marked with methylene blue. Only after the face has been lifted, including the forehead and neck, do we start the blepharoplasty. In our opinion, this creates a bigger amount of skin in the lower eyelid, allowing a larger resection, and on the other hand, diminishes the necessity of resection at the upper eyelid. We also make an electrocoagulation of the orbicularis muscle at the upper eyelid especially at its external angle, with the purpose of a real and permanent fixation due to the muscle shortening and contracture. This procedure also lessens the formation of palpebral folds at the moment of suture.

We always use two drains: one at temporal region and the other at an retroauricular region. But they are not sufficient to prevent skin damage in the presence of hematoma. That's the reason why we have developed a special tensiometer, with which at any moment, without lifting the bandages and even by nonspecialized personnel, any small formation of hematoma can be detected.

MALPOSITION OF THE EYEBALL: AN UNUSUAL COMPLICATION FOLLOWING BLEPHAROPLASTY

LEMONS, P.

A very unusual complication is described and its possible occurrence and control are important to know, because any time it happens, one must not be desperate.

One woman in her sixties underwent a face-lifting together with blepharoplasty and dermabrasion of the frontal wrinkles. Before the operation the clinical picture was normal except for a slight rise in the blood sugar, well-controlled by the internist. No previous references of ocular diseases were mentioned.

The operation, under general anesthesia (nitrous oxide), and local infiltration with xilocaine 0.5 % and epinephrin 1/150,000, went in normally. Before blepharoplasty we observed a severe degree of conjunctival edema, controlled with some drops of local corticoid. Lid skin was removed and also some fat from both eyelids.

The day following the operation, a very severe degree of edema was noticed. Heavy anti-inflammatory medication was applied consisting basically of enzymes, antibiotics, and corticoids. After four days the edema subsided and the eyeballs were seen, revealing a terrible surprise: the left eyeball was in the normal position, but not the right one. When the patient looked in front, the right eyeball moved up; when looking down, it came to the normal front looking; when looking up, it completely disappeared under the upper lid. The lateral movements were also dis-coordinated. The upper right lid showed also a certain degree of ptosis.

We made a diagnosis of neuropraxia, due to unusual edema and compression, and medication with vit. B12, B6 and B1, was initiated, beginning with 15,000 micrograms of B12, and 5,000 every other day, together with enzymes, and corticoids. Little by little the edema diminished and the eyeball came to its normal place and function which, occurred three weeks after the operation. Another explanation could be the existence of a hematoma in the floor of the orbit, raising the eye and compromising its function.

A BASIC CONCEPT OF REDUCTION MAMMAPLASTY

BERRY, E. P.

The difficulties that are often encountered in reduction mammoplasty, particularly in a training center, have become more and more apparent these past few years. Operations that are successful in the hands of certain excellent surgeons are not always as satisfactory in the hands of a trainee. The author presents a basic concept, which gives satisfactory results.

TECHNIQUE OF MAMMAPLASTY IN PTOTIC AND HYPERTROPHIC BREASTS CONDITIONS

GOUMAIN, A. J. M.

After abandoning, like many others, the operation of Biesenberger because of the inconstancy of its results, the writer describes the technique which he has been using for more than eight years with complete satisfaction both from the point of view of aesthetics and from the point of view of safety.

This technique is based on two principles generally acknowledged today:

1. Conservation of both internal and external mammary vascular pedicles.
2. Cutaneous undermining limited to the surface of the glandular exeresis.

But, contrary to almost all the present methods which involve a preliminary pattern of the simultaneous exeresis of the skin and of the gland, the writers remain faithful, with a minimum of preoperative reference points, to the separate exeresis of the gland and of the skin, with a cutaneous dressing upon request of the reduced and modeled gland, thus achieving a «made to measure» operation during which it is always possible to make detailed modifications.

The reduction of the hypertrophy is carried out:

- either according to the schema of Pitanguy by the association of a triangular exeresis more or less extended to the lower half of the gland, of a thinning-down of the gland at the expense of its deep pectoral face and eventually the excision of a dihedral at the upper pole.
- or, in important hypertrophies, according to the schema of Matthews, through the sacrifice of a vast lower crescent affecting almost the whole of the lower half of the gland, completed, if it is still necessary, by the same exeresis in depth and of the upper pole.

But in all cases, in order for these complements of exereses to be licit, it is absolutely necessary for the remaining gland to adhere closely to the skin from which it should not have been separated and for these exereses to be carried out in depth.

Thanks to this technique, with satisfactory results from the aesthetic point of view and without any complication of necrosis whatsoever, it is possible to carry out mammoplasties with reductions which may reach 800 to 1,000 grammes.

REDUCTION MAMMAPLASTY, PERSONAL CONCEPT CONCERNING GLANDULAR RESECTION

PONTES, R.

The appearance of a new surgical technique is generally due to personal adaptation and modification of preexisting methods. One can say, that the mammoplasty had its start with the breast amputations of former days, as a coarse way of reducing weight. As plastic surgery evolved, not only the reduction, but also the functional aspect and the sensibility of the organ were considered objectives of a satisfying surgery.

The methods subsequently developed, for the most part dissociating the treatment of skin-gland, used wide undermining and were subject to such complications as necrosis, haematomas and loss of areolar sensibility.

The great step in mammoplasty, in our opinion, was made by Pitanguy, who, parting from the principle of not dissociating skin from gland, developed a technique, which succeeded in remarkably simplifying this surgery and practically eliminating the usual complications. Oriented by this technique, we developed a variation, based on a greater resection of the tissue in the lower internal and external regions, avoiding the medial removal in wedgeform.

The lines of resection are curved, of lower concavity, accentuated on the external part, which permits an extensive removal of tissue in this region, ensuring a better shaping of the breast. The gland is cut perpendicularly, crossing approximately 2 centimeters of the inferior border of the areola and accompanying the curved outline of the lateral slopes.

The operation is repeated on the opposite side and the two mammary stumps are subsequently compared and in case they are not identical, a complementary resection is effected. The breasts are mounted with chromic 3-0 catgut and 5-0 nylon, ending at the areolas, which are sutured in their new position. The wound is protected with gauze and the procedure is completed with a plaster brassiere.

We believe that by this method the resulting breasts are firmer and more graceful.

CONSIDERATIONS ON MASTOPLASTY

PIOTTI, F.

The writer in an earlier paper presented to the 18th Italian Congress of Plastic Surgery in 1968, and later published, refers to his personal case histories of mammoplasty utilizing the Pitanguy technique. He recalled that this method, based on the techniques of Arie and Pitanguy, as described in 1959, had resulted in a surgical technique both easy and rapid to carry out after changes and improvements were made. The writer claims, however, that this method is preferably suited for simple ptosis and for slight hypertrophy of the breast while, according to him, in severe hypertrophy it was not possible to carry out the method to the letter, but that it was necessary to incorporate other surgical maneuvers: different kinds of undermining according to the case at hand, removal, at times, of cylindrical glandular-adipose tissue (Strömbeck technique), with attention being focused on the importance of incision length (the vertical not more than 5/6 cm.) and on the accentuation of curvature of the submammary incision at both extremes. Again, in cases of severe hypertrophy, for the purpose of avoiding the joining of the submammary sutures at the midsternal line, it was advisable to, double, the suturing at the extreme medial and lateral angles in two small horizontal V's, intersecting a small triangular flap.

The writer has continued to use this technique of mastoplasty especially in cases where it is not possible to avoid the undermining of the tissue, and does not accept the popular idea that the most important function of the skin is to support the gland, acting as some sort of suspension apparatus. Therefore he added certain small changes to the Pitanguy method for the purpose of assuring better results, also after a certain lapse of time (see case histories). In particular, as far as infraposterior glandular resection is concerned, the writer claims that it is preferable not to carry it out uniformly but, instead, to remove a portion on the right and on the left keeping a certain amount of glandular adipose tissue in the medial part under the areola to ensure greater consistency in the center of the gland. Each one of the two cavities thus obtained is then sutured with a triple stitch to tie it to the fascia of the chest wall. This change, according to the writer's opinion, helps to secure the gland in an opportune position.

SPECIAL TECHNIQUES IN BREAST REDUCTION BASED ON THE METHODS OF STRÖMBECK AND SKOOG

HARTEL, P.

Reviews on methods of breast reduction usually lack pertinent information on details of operation procedure. However, often such details may be crucial for a successful result.

Essential steps in the method of breast reduction as outlined by Strömbeck and Skoog are briefly indicated. The following special features are demonstrated:

1. At the submammary fold a residual triangular flap should be kept in order to prevent epitheliolysis or other skin defects at this area of maximal tension after suturing.

2. In cases of substantial lateral projection of the breast, the suturing of the lateral skin flaps should be performed somewhat more medially in the area of the submammary fold. This counteracts lateralization of the reduced breast.

3. An improvement of mobilisation of the nipple flap may be obtained by incisions up to 1 cm long at the upper corners of the lateral skin flaps. Concomitantly, the base of the nipple flap is extended toward the lower corners of the lateral skin flaps, thus ensuring adequate blood supply of the nipple.

4. Superficial as opposed to more deep sutures for closure of the lateral skin flaps largely exclude possible impairment of blood supply of the nipple flap.

5. The problem of a conical resection to obtain a more marrow, reduced breast is discussed. Such a resection could lead to aseptic necroses of parts of the glandular tissue.

6. Intradermal sutures carried out in the continuous rather than simple loop manner are less time-consuming and lead to less scar formation.

7. The use of contraceptive pills is not recommended for the period of six months after the breast reduction.

REDUCTION MAMMAPLASTY BY A COMBINATION OF PITANGUY'S AND STRÖMBECK'S METHODS

CARRATO, R. H.

Breast reduction is indicated in the presence of mild or heavy mammary hypertrophy, by resection of skin, fat tissue and gland, or as well in the cases of mammary ptosis when only skin is reduced, followed by mastopexy. Histologically, mammary hypertrophy is characterized by a proliferation of the connective tissue and ducts: adenofibrosis, fibroadenomatosis, chronic mastites with adenosis. We have been using the Thorek technique with subtotal resection of the mammary gland and free graft of the nipple. Although this technique gives a very low rate of complications and some very good aesthetic results, in our opinion it should be used only for the very heavy and giant mammary hypertrophy since the sensitiveness of the nipple is abolished and there is no further possibility of lactation. For the mild hypertrophy and ptosis we have utilized a combination of Pitanguy's and Strömbeck's techniques with a cuneiform resection and no skin undermining. After the wedge-shaped resection has been made, we also make a small circular resection at the superior pole to facilitate the nipple transposition. The association of these two techniques allows a bigger resection of glandular tissue than any other technique. Usually we resect 500 to 800 gr. of each breast, although we have reached the exceptional weight of 2,500 gr. But the complications increase from 0.5 % to 25 % when the resection weight exceeds 1,000 gr.; and among these we quote: complete or partial necrosis of nipple, necrosis of skin and fat necrosis, and loss of sensitiveness.

Concerning the scars of patients reviewed 6 to 12 months after surgery, we have observed the following conditions: keloids - 2 %, hypertrophic scars - 30 %, scarring of good quality - 55 %, and of excellent quality - 13 %.

REDUCTION MAMMAPLASTY

LEWIS Jr., J. R.

The author presents the evolution of his own technique for reduction mammaplasty for the ptotic breast and for the hypertrophic breast. A description of the technique which he now uses and has used for a number of years will be given in more detail and illustrated by a number of colored slides illustrating the technique and the results. This technique is a combination of the inverted keel wedge resection as described by Pitanguy and as modified by the author for reduction of the breast mass, and the outlining and the elevation and shaping of the skin flaps according to patterns described by Wise and modified by the author. This technique is remarkably standard for the breast which is very large or very ptotic and for the breast which is smaller, less ptotic, and which may have variations in size, shape, contour and breast position.

In the author's hands this technique achieves those qualifications which make a technique good in a large percentage of cases and fulfills the qualification of: 1) a technique simple enough to be relatively standard and achieve symmetry in a high percentage of cases; 2) a technique which adequately reduces the skin brassiere and the breast mass; 3) minimal obvious scarring; 4) adequate circulation and nerve supply to nipple and areola; 5) good breast contour with projection of the breast and with the nipple at the apex.

Variations in technique which seem suitable for specific cases will be described, particularly as to the variation in the types of ptotic breasts. A description will be given of: 1) the correction of ptosis by utilizing available breast tissue; 2) the correction of ptosis by use of a prosthesis, and 3) the correction of ptosis by a combination of prosthesis and skin resection with reshaping of the available breast mass.

THE DOUBLE-BREADED BREAST

VIÑAS, J. C.

In 10 cases a surgical technique was employed for the treatment of mammary ptosis with moderated hypertrophy which, owing to the form given to the mammary tissues, has been named «double-breasted breast».

Its surgical steps are:

1) On the skin of the breast the periareolar incision is marked out, and from this, a vertical line is drawn bisecting the breast. This extends downward as far as the submammary marking which will constitute the submammary fold after the operation.

This latter line must be located some 2 to 3 cm. above the existing mammary fold. It must not be longer than 12 cm.

2) Both cutaneous flaps are dissected to expose the gland in the lower half of the breast and to extend the dissection in the middle part for about 5 or 6 cm. above the areola.

3) With both flaps apart the lower face of the gland is cut vertically and a portion of the glandular tissue, in the form of a cone or pyramid, based on the pectoral plane, is removed.

Once this has been done the mammary gland has the form of a hollow cone with its opening towards the lower face such that it may be compared, schematically, to an Indian tepee.

4) Both lateral gland flaps are detached from the pectoral plane and the medial flap is rolled up the cavity, and fastened there with two catgut stitches.

Following this, the lateral flap is folded inwards on top of the other, rather tightly, and fastened with a few stitches in this overlapping position, as the two halves of a double-breasted suit.

5) The nipple is brought to the position that previous marking indicates and excess skin is removed.

The technique is functionally conservative and the structure obtained, like a paper cone, is considered optimal from the point of view of structural solidity. The height to which the submammary fold is lifted helps to conceal the scars.

SURGICAL TREATMENT OF HYPOTROPHIC BREASTS AS A RESULT OF OBESITY PREVIOUSLY TREATED: A PERSONAL TECHNIQUE

FAIRMAN, J. M.

At the Latin-American Congress of Plastic Surgery in Sao Paulo 1960 and at the III International Congress of Plastic Surgery in Washington in 1963, we presented the results obtained in the reconstructive surgery after complete mastectomy for fibrocystic mastitis according to a personal technique based on the immediate reconstruction of total amastia by the use of dermo-fat flaps (Longacre).

Considering the satisfactory results obtained with this procedure, we also used our technique for treatment of hypotrophic breasts.

This technique uses the dermo-fat flaps enclosed within the horizontal marks and the submammary sulcus, from Strömbeck's patterns. By rotating and elevating these flaps, they are placed deeply inside and held by one stitch that fixes their distant edge to the second or third intercostal space at the projection of the meridian of the gland.

The rest of the operation is completed with the routine technique, leaving the transposition of the nipple for the last stage.

We have developed this method by taking into consideration the fact that during the last few years the treatment for weight reduction has become more frequent every time. There are cases in which the patient loses 100 or even more pounds. This reduction of weight is obtained as a result of the corresponding diminution of the fat tissues, which leaves a flaccidity at the affected areas.

It very often happens that these patients present a neurotic component which makes them regain weight once more. These upheavals markedly affect the elasticity of the skin and consequently produce more flaccidity.

Even though the psychological component is at present well taken care of and patients are clinically treated, it is of the utmost importance to break this vicious circle and help the patient to regain confidence in herself.

In the particular case of the breast, we consider that the so-called hypertrophic breast with ptosis is produced by marked reduction of the fat tissues, thus resulting in what we call **hypotrophic breast**.

MODIFICATIONS IN BREAST-SURGERY: TECHNIQUE USING A BURIED INFERIOR-BASED PEDICLE

RIBEIRO, L.; BACKER, E.

The authors feel that for small and medium hypertrophies and ptosis, the usual techniques offer a good solution. However, in large hypertrophies, surgery always ends by a free graft of areola which is not pleasant when the patient is young and has had no children. Another problem concerns the very flaccid breast where surgery is relatively easy but, as time goes by, the breast drops, spreading the scars, and projecting the nipple upwards. This seems to be due to the poverty of elastic fibers which do not hold the weight of the breast.

Therefore the authors developed a pedicle with an inferior base, of variable size, obtained from the very area to be resected which, after decortication, is left out of the surgical procedure. Then the usual techniques are employed (generally Strömbeck or Pitanguy) and the excessive tissue is resected since the pedicle is safe for such resection. Thus the advantage of this pedicle is the safety it gives to the surgeon, particularly for the young ones, who are generally afraid of carrying out any excessive resection.

This pedicle is fixed in a tunnel under the breast at the level of the superior pole over the pectoralis mayor muscle, where it is held with notabsorbable thread.

As advantage the authors point out:

1.º Safety in surgical procedure avoiding invagination of the nipple in building the breast.

2.º It gives a larger contour due to its fixation through the tunnel.

3.º Because the above, mentioned fixation, the pedicle holds the weight of the breast better, avoiding a late ptosis and therefore spreading of the scars, thus maintaining the nipple in the position it had immediately after surgery.

4.º In large hypertrophies it avoids the use of the graft of the areola.

Summarizing, the authors think that this pedicle functions like a plasty where there is an inversion in the position of the flaps, thus balancing the residual mammary weight and producing a more aesthetic shape of the breast.

BREAST RECONSTRUCTION BY THE DERMAL MASTOPEXY TECHNIQUE

GOULIAN, D.

Where mammary ptosis is the problem present, restoration of breast contour is possible with no actual surgery on breast tissue. Retention of dermis in the areas where excess skin is excised and folding the breast upon itself into the new breast contour is the basic plan. Because there is no skin undermining and since scarring of dermis itself provides a strong union, there is more permanent retention of the desired breast contour, lowered operative morbidity and more acceptable appearing skin scars.

A simple modification of this operative technique can be used in justifiable situations to provide wide access to the underlying breast, allowing subcutaneous mastectomy and simultaneous breast restoration, utilizing the available dermis-fat components for volume.

Where breast volume is inadequate for providing an acceptable breast contour, an implant can be placed either at the time of initial surgery, or at a later stage, to complete the restoration.

Where minor asymmetries of the breast exist preoperatively, these can be corrected easily during the procedure by simple modifications of the basic technique.

A series of diagrams and clinical cases demonstrating these uses will be presented.

MASTOPEXY WITH AND WITHOUT AUGMENTATION

LERNER, S.; TITTRANUNDA, T.; AIACHE, A.

The authors present their experience with mastopexy for ptotic breasts. The specific new technique used is based on a variation of the Strömbeck pattern and is applicable to the small ptotic breast with and without silicone prosthesis implant.

The principle of this procedure is the reconstruction of the skin bra of the mammary gland without discarding any tissue except epidermis. A specific incision has been described which does not jeopardize the vascular supply to the pedicles or nipples, and for insertion of the silicone prosthesis during the mastopexy procedure.

Illustrative cases with diagrammatic presentation of the operative technique will be presented as well as postoperative results.

ORGANIC MAMMARY AUGMENTATION

FONSECA ELY, J.

With the increased development of mammary prosthesis presenting better tolerance, higher quality and larger diversity of shapes, hypomastia is almost a synonym for prosthesis indication.

Not denying the unquestionable value of the use of prosthesis, we would like to draw attention to the still valuable use of organic tissue to treat hypomastia.

Basically the surgical procedure is developed in three main steps:

1) The excess skin is de-epithelized and whenever necessary, every centimeter of dermis and subcutaneous tissue, corresponding to the inferior part of the breast, is used. The lateral extremities are sutured to the pectoral fascia, under the medial part of the breast, forming a cone-shaped cushion.

2) The inferior pole of mammary tissue is plicated vertically and sutured by imbrication in two layers, transforming a spreaded base into a narrow one, thus elevating the apex of the cone.

3) The skin cover is advanced toward the vertical line, the inverted «T» line of suture, thus giving a good modeling support to finish the new conical shape of the breast. According to each particular case, the line of suture can be either vertical or oblique, instead of the described «T».

The amount of augmentation depends on the quantity of tissue transposed, and the height of forward projection is controlled by the grade of conical displacement. Considering the inverted «T» as a combination of elliptical excisions, the vertical one increases the height and the horizontal one decreases it. Therefore we can control the adequate size of the re-shaped breast according to the thoracic and body proportions.

In conclusion, a series of cases of mammary augmentation with organic autogenous tissue is presented, this method being considered a useful procedure in selected cases.

REDUCTION MAMMAPLASTY: OUR LATEST EXPERIENCE

LALARDRIE, J. P.; JOUGLARD, J. P.; MOREL-FATIO, D.

We have become convinced that in order to have long-lasting results it is necessary to reduce the glandular volume to the minimum compatible with the bodyshape, and to construct a dermic vault of which the nipple forms the key.

The procedure we have used originates in those which have been recently described. It leaves, however, only a thin layer of glandular tissue of homogenous thickness.

The two lateral vascular pedicles are cut: this allows considerable exeresis. Our experience is based on 200 cases operated on within the last three years.

A METHOD OF SEWING UP AFTER THE PASSOT TYPE OF BREAST REDUCTION

WALKER, H.

This paper will describe a technique developed by me for sewing up the breast and making a prominent nipple contour (after free transplant of the nipple) after the Passot type of breast reduction. A well-known disadvantage of the Passot-type reduction is, of course, the flat-chested appearance which results.

SURGICAL POSSIBILITIES FOR THE TREATMENT OF MAMMARY DYSMORPHOSES

GOUMAIN, A. J. M.; FEVRIER, J. C.; FEVRIER, M. F.

The most common mammary dysmorphoses are the hypertrophies, hypotrophies, ptoses, asymmetries, umbilication of the mammilla, those brought about by the presence of benign tumors in the breast, by the exeresis of a cancer and by serious burns of the thorax.

There are two varieties of hypertrophies: the isolated hypertrophies in young girls and those which come within the framework of a general obesity.

Without going into the details of the surgical technique, it is useful to note that:

The mammary gland is vascularized by the skin from which it must not be separated.

The mammilla must itself remain in one piece with the skin at the cost of a desepidermisation which allows its sensitiveness and its erectility to be maintained.

The glandular resection is spread over the whole of the mammary gland which is sufficiently undermined from the thoracic wall.

During the remodelling of the breast, the mammilla must be placed low enough for it to resume its normal position during the months following the operation.

The scar in the form of an inverted T—or oblique if it concerns a small hypertrophy—must be conceable by the very smallest swimsuit bra since it sometimes becomes ugly and may need secondary treatment.

The very voluminous hypertrophies or those associated with a large ptosis depend on the modelling resection with free graft of the mammilla.

The congenital or acquired hypotrophies depend on the inclusion of protheses in silicone. They are tolerated perfectly and allow very satisfactory results to be obtained from the point of view of shape and scar but are less satisfactory, in so far as consistency is concerned.

SOME HINTS IN MAMMAPLASTY

FRANCO, T.; MAGALHAES, E.; LION, P. M.; REBELLO, C.

In the management of mammary dysplasias surgical tactic is more important than surgical technique. Every technique may lead to good results when well-mastered.

By showing some hints that the authors have found very useful after long experience, they hope to contribute to the improvement of results of younger plastic surgeons.

RECONSTRUCTION OF THE FEMALE BREAST

CHOLNOKY, T.

Reconstruction of the female breast consisting of various operations for total reconstruction for congenital absence of breast; and breast reconstruction after simple and radical mastectomies. Illustrated with 35 mm., Kodachrome slides and moving pictures.

BREAST RECONSTRUCTION AFTER SUBCUTANEOUS MASTECTOMY

SIMONIS, A. A.

The historic development of reconstruction of the breast is reviewed bringing us to the modern technique of augmentation mammoplasty, using a silastic prosthesis.

The standard procedure is evaluated as used on a large group of patients with such different indications as: hypoplasia, aplasia, involution atrophy and congenital asymmetry.

A special group is singled out:

Patients with unilateral or bilateral pathology of breast tissue as occurs in adenofibrosis, cystic disease, chronic mastitis and in some malignant growths of the breast.

Most of these patients present themselves with scarring as a result of previous biopsies, and are referred to the plastic surgeon because, while amputation of the breast is not yet indicated, subcutaneous mastectomy is advisable.

A surgical technique is described where, after performing subcutaneous mastectomy, we try to achieve a lined cavity by using a stents mould. At a later date the stents mould is removed and replaced by a silastic prosthesis. The same incision is used and the procedure carries less risk than a standard augmentation.

BREAST RECONSTRUCTION AFTER TOTAL EXERESIS OF THE GLAND FOR BENIGN TUMORS

SINDER, R.

Total extraction of the mammarian gland usually results in a flat breast.

Such techniques vary from many types of inclusion to the use of grafts and flaps.

Flaps with superior or inferior pedicles (Burian, Mariano, Longacre, etc.) give good results in most cases.

In seven patients whose whole gland was removed, we reconstructed the breast with a very simple technique that we describe in this paper. It deals with 4 patients with polycystic disease of the breast and 3 patients with cystosarcoma phylloides, in one case, on both sides.

STAGGERING THE SEVEN PILLARS OF WISDOM IN BREAST SURGERY

PERRAS, C.

From an experience based on 2500 breast implantations, the author will expose a series of complications, analysing their causes and ensuing treatment.

SOME VARIATIONS IN TECHNIQUE IN THE USE OF THE SILASTIC GEL BREAST PROSTHESIS

CRONIN, T. D.

Although 8 different sizes of the prosthesis are available from The Dow Corning Co., additional adjustment of size and shape can be achieved by extraction of some of the gel in certain areas or by the addition of saline. On occasion deliberate incision of the sac may be useful. Sometimes subpectoral implantation may be indicated. Contracted fibrous capsules may respond to relaxing incisions and/or reduction in volume.

After subcutaneous mastectomy, immediate restoration of a pleasing or even improved breast may be attained. Thin areas may be strengthened with patches of dacron mesh.

ORGANIC REACTIONS TO MAMMARY INCLUSIONS

MARTINS, L. C.; COURVELLO, W.; FRANCA, W.; SERSON, D.

The authors present their experience in the treatment of hypomastia, for which Cronin's type of prostheses was used and in a lesser number of cases the inflatable type.

The complications and alterations of shape after 2 years are presented. Histological and clinical studies of the membranous reaction to the implant are

CLINICAL AND MORPHOLOGICAL CONSIDERATIONS ON «CONSTRUCTIVE FIBROSIS» CAUSED BY SILASTIC IMPLANTS

WILFLINGSEDER, P.; PROBST, A.

The fibrosis and thickening as well as shrinkage of the connective capsule in cases of Silastic prosthesis, introduced mostly through retromammary implantation, are commented on and conclusions made, based on histological examinations.

THE AREOLAR APPROACH TO AUGMENTATION MAMMAPLASTY AND THE USE OF THE INFLATABLE PROSTHESIS

JENNY, H.

This new approach to augmentation mammoplasty has been used for the last three years on approximately 200 patients. The central location of the incision on the breast to be augmented, or biopsied, and the technical simplicity of dissection and hemostasis under direct vision make it an ideal procedure. Most of the augmentation mammoplasties have been performed under local anesthesia, using preoperative sedation and one-half percent Xylocaine with Adrenalin for infiltration anesthesia. The technique of postoperative dressing and subsequent care are demonstrated.

The physiological, psychological and aesthetic function of the female breast is subsequently discussed. Reasons are given as to why the new prosthesis is of a simple discoid shape, inflatable and unattached to the surrounding tissues. In the course of the discussion, some of the existing theories on the mechanism of attachment such as dacron patches are questioned.

Since most of the postoperative follow-ups have been documented by color slides only showing the shape of the breast with the patient in an upright position, attention is paid to the consistency of the breast. Therefore, a new classification emphasizing the softness and mobility of the augmented breast is given for the purpose of a more useful and accurate postoperative evaluation. The entire group of patients is divided into those who had inflatable prosthesis and those who had other types of prosthesis. The complications are discussed, dividing them into those concerning the mammary prosthesis and those specifically for the surgical approach. Special emphasis is given to the theory of a delayed foreign body reaction to silicone with an explanation for the contracture of the pseudocapsule.

GYNECOMASTY: SURGICAL CORRECTION BY USE OF A Z-INCISION IN THE AREOLA

SINDER, R.

The oldest techniques for correction of gynecomasty used an incision below the areola (mammarian fold).

Despite the good shape obtained by the method, the scar was frequently very noticeable and unpleasant for the patient.

In 1932 Ricardo Finochietto published a work called «Mama, la via areolar», showing a method to remove benign tumors of female breasts by an incision just near the lower half of the areola.

In 1946 Webster presented the use of this incision for surgery of gynecomastia with excellent results because the scar is hidden by the areolar lower limit.

In 1954 Lynch proposed to add a little horizontal skin incision just lateral to Webster's incision, to facilitate hemostasis in larger gynecomasties.

This indeed facilitates hemostasis but sometimes it might be antiaesthetic.

In 1966, Pitanguy presented the horizontal incision crossing the middle of the areola (equatorial incision), also with good results, as the scar is also hidden by the pigmented area of the areola.

Personally, in cases where the amount of tissue to be extracted is very large we use a Z-incision with curved branches near the areola, and its central part in the equatorial areolar line. With this incision we got large access to do hemostasis and the resulting scars are not very visible because they are all within the areola and its limits. We did not have any complications in 14 cases using this technique.

AESTHETIC SEQUENCE TO REJUVENATION - FIRST STEP RHINOPLASTY

WYNN, S. K.

It has been found that in many patients past the age of 35 years, performing a rhinoplasty will help their appearance to the point where they do appear younger which is the desire of the person in this age group that first contacts one for rejuvenation. I find that this is a very satisfactory way of getting an individual back on the way to a youthful appearance without going through a facelift procedure too early for the type of skin she may have or the expectations that the individual has in her mind at this age. The paper will illustrate various cases in this age group and what can be done for them. The techniques used for rhinoplasty to accomplish the result and a discussion of the stages and procedures over a period of years in keeping the woman youthful in appearance are shown.

THE STENCIL TECHNIQUE IN RHINOPLASTY PLANNING

HOLMSTRAND, K. E.

This paper describes a simple method for making a stencil used in rhinoplasty. The stencil besides being used for achieving accuracy in the planned profile also lends itself to an effective checking on the postoperative settling of the nose.

PREDETERMINATION OF THE NASAL SHAPE

VARGAS, A.

A few years ago we began a study to obtain the predetermined form of the nasal shape of an adult using the childhood form as a base. In order to establish some conclusions we have taken photographs, X-Rays and made extensive studies of the nasal pyramid in children, adolescents and adults seeking a morphologic evolutionary classification which would permit us to relate the childhood nose to its future figure or form and also help us to analyze the different transitional forms.

We will now present and explain various case histories and their procedures. We sincerely hope that this study will be of sufficient interest to obtain the collaboration of all our colleagues. It would be a great step forward if this investigation could also be carried out by other groups from other countries.

GRAPHIC ANTERIOR ADJUSTMENT IN AESTHETIC SURGERY OF THE NOSE

GONZALEZ, R. A.; OJEDA, F. X.

This is the evaluation of nose surgery from the antero-posterior point of view. The measure and reduction concerning the nasal osteotomy are calculated when performing hump-resection, completing the study of well-known profile-plasty.

We now wish to graphically demonstrate the dimensions in connection with the function and morphology of the nasal pyramid pre and postoperatively.

PIOTTI, F.

The writer refers to rhinoplasty which attempts to reshape the architectonic elements of the nasal pyramid caused by hypertrophy or depression and to those alterations of form that can disturb the harmony of the face from the anthropometrical standpoint. The origin of anthropometry stems from the need for laws governing what constitutes the so called ideal man (P. Broch, 1876), and that resulted in the setting down of ideal proportions and measurements for the various parts of the body. The conditions of present day-life have altered the psychology of people to such a degree that they have become more conscious of not being able to stand certain anomalies as well as developing complexes concerning any obvious physical characteristics and features, resulting in severe criticism of the results obtained through rhinoplasty requested by and performed on them.

Referring to personal case histories of 362 cases treated by rhinoplasty in the triennial of 1969-1971, it was found, by means of background history, that about 45 % of these patients suffering from this psychopathological condition managed to subdue and control it. As proof of this, we cite the fact that many had undergone psychiatric or psychological treatment. The writer, after having illustrated and made observations on the techniques of rhinoplasty personally carried out by him, recalls that the surgical methods which are available to us are many and that each surgeon prefers one to the other since it is all a question of choice on the part of the surgeon. In conclusion each technique holds within itself positive aspects, but the essential and most important point is how a particular method is applied, carried out and varied. Rhinoplasty is a surgical operation that demands specialists who are able to give the greatest guarantee of its success; specialists who in the light of their competence and experience can give, from case to case, either voluntarily or unconsciously, that certain personal touch designed to reach and achieve the greatest satisfactory results possible, thus giving greater guarantee for the final result of a rhinoplasty operation avoiding those serious negative consequences which can be observed in patients operated on by less competent surgeons. Some cases taken from personal case histories are shown and commented on and some cases of rhinoplasty are shown which were carried out elsewhere with serious negative results.

RHINOPLASTY: PERSONAL IMPROVEMENTS ON STANDARD TECHNIQUE

DARGALLO, I.

The author describes the standard procedure for rhinoplasty based on his personal experience and modifications of technical details. The preoperative planning is described.

The tip repair is performed at the beginning of the surgery, performed under general anaesthesia, as it is felt that this allows better judgement of the amount of cartilage to be excised; bleeding and oedema development due to surgical trauma after osteotomy may later complicate the evaluation.

The alar cartilages are dissected and everted, and injection of saline solution is used to facilitate the dissection of the cutaneous mucous lining, which is preserved.

Depending on the width of the alar cartilage, a hockey-stick type resection or excision according to Serson with preservation of the lower rim is used. In cases of bifid nose, the author sutures both medial crura together, after removing the soft tissue between both. In cases of thick cartilage, the upper rim is trimmed obliquely in order to minimize an externally visible sharp edge.

After dissection of the dorsum and elevation of the periosteum as far as half the height of the nasal bones, the hump is resected by means of Joseph's saw and McIndoe's chisel in cases of prominent fronto-nasal angle and completed with a curved bottom scalpel, the surface being smoothed with rasp. Any excess of mucous membrane is removed in order to avoid postoperative irregularities and swelling of the dorsum.

Medial osteotomy is performed with the straight Silver nasal chisel and the lateral osteotomy with curved Silver chisels through a separate subperiosteal channel, the bones being outfractured with Asch's septum forceps.

Finally the lower septum border is conveniently shortened.

A preoperative plaster mask is made and used for comparison with the end result. For fixation, tape and cast are used for 1 week, the tape being removed 4 days later.

SURGICAL TREATMENT OF THE NASAL TIP, BY SERSON'S TECHNIQUE

BRAGADINI, L. A.

We have used many methods to treat the nasal tip in order to arrive at the best goal with the simplest surgical means.

Each of the methods used are profitable for reducing the cartilagenous frame of the nasal tip in height and width, but we found that Serson's technique is one of the simplest operative ways to get it.

After a rim incision, he obtains a condromucous flap with the dome and the highest part of the lateral and medial crus. At this moment, the incision splits the alar cartilage in:

1) The remanent alar rim band, narrowed and weakened, so the deflection angle becomes more internal and acute, projecting the nasal tip.

2) The liberated flap, free of the neighboring attachments and with the resection of tissues, becomes proportionally longer, according to the rim cartilage band «new angulated» and this excess shows us the line of excision.

Serson says that with this technique he obtains a shortening of the nose so that he never needs to shorten the septum. We found that in cases with long septum we need to do it in order to obtain a new columellar-lip angle of 100° in women and of 95° in males.

INTACT ALAR RIM COMBINED WITH HIGH SEPTAL TRANSFIXION IN RHINOPLASTY - 20-YEAR EXPERIENCE

WEBSTER, R. C.; WHITE, M. F.; COURTISS, E.

Well over 20 years experience with variations of these combined techniques allow us to conclude that:

1. Tip projection can be provided in a predictable manner;
2. Tip definition can be provided even in most thick-skinned noses;
3. Alar, lobular, and columellar notching and pinching are avoided;
4. Many large hump removals, major mesial shifts of lateral walls, and septal shortenings are eliminated;
5. Excellent access to the areas above the limited incisions is allowed;
6. Resections or shape modifications of the medial crura between or posterior to the domes allow tip narrowing, levelling, or retrodisplacement;
7. Upper lip lengthening, shortening, plumping, and columellar-labial angle changes can be made with ease and relative certainty;
8. Alar base resections are needed less frequently;
9. Excessive width of nose is corrected by resections of lowest or recurving portions of upper lateral, sesamoid, and much of the upper part of the lateral crura of the alar cartilages;
10. Morselization allows further refinements.

Dangers in thin-shinned tips and contraindications to this technique will be shown.

A TECHNIQUE FOR THE SURGICAL TREATMENT OF THE TIP OF THE NOSE BY MEANS OF TWO MUCOSAL FLAPS

CARONNI, E. P.

Very often the bad result of the tip of the nose after a rhinoplasty treatment may impair the total result even if all the technical details have been carefully respected.

We have been using a method for some time which does not seem to have been illustrated before. This method utilizes two mucous flaps of the vestibule for joining the «crus» without producing an unnatural look which the nose tip shows when the «crus» is reconstructed and fixed.

This method uses two triangular flaps sculptured in the nasal vestibule very near to the angle formed by the wing and the columella, which are joined behind the «crus» through an exposed flap that lies on the upper exposed margin of the quadrangular cartilage.

This technique enables us to obtain a reduction of the nose tip's width without fixing the «crus», that remains free and mobile.

Very important is the point where the two triangular flaps are carved and the choice of this point depends greatly on experience. If the point is not properly chosen and the mucous flap has a base too low, unpleasant and antiaesthetic depressions may occur at the sides of the nasal wings. On the other hand, we may not obtain the desired result and may even worsen the situation if the mucous flap has too high a base.

Using this method, a correct tip of the nose, accompanied by an absolutely natural look, can be obtained.

RHINOPLASTY WITH TRIANGULAR RESECTION OF THE ALAR CARTILAGE AND ANCHORAGE SUTURE

ESCOBAR BOURGUET, P.

There are essentially two indications for corrective rhinoplasty:

1. To obtain a correct function or to preserve it.
2. To acquire the beauty of form which is compatible with the face.

In the technique I describe, after performing the Rhinoplasty in its phase of hump removal, bone-fracture and shortening of the lateral cartilages in the usual way, the sculpturing of the lobule is performed, by totally isolating the alar cartilages on both faces by resecting a triangle of variable size and morphology, depending on the specific problem. The base of resection is located in the superior border of the cartilage, this space is shut automatically after elevating the tip, once the piece of the inferior portion of the septum has been resected.

To diminish the width of the tip and consequently of the whole nasal base, the mesial portion is traversed with a nonabsorbable material which closes the central portion of cartilages, and permits the elevation and better location of the central portion of the alar cartilages, giving an adequate dimension to the tip and a satisfactory morphology which is not usual with the habitual technique. The technique as well as the results obtained are shown on color slides.

NASAL RECONSTRUCTION IN THE NEGROID NOSE

AIACHE, A. E.; SILVER, L.; BARSKY, A. J.

During the past decade with changing economic and social structures, we have noted a progressive increase in the interest in aesthetic surgery in Negro men and women. In the case of nasal plastic surgery, specific differences between the Causasian and Negro nose exist, which necessitate a slightly different approach with certain special techniques which we have found helpful in obtaining better results.

Three basic areas, the bridge, the tip and the nostrils must be analyzed.

The Bridge

We correct the characteristic low bridge, usually by implants; carving an iliac bone strut, anchored to the nasal bone pyramid.

The Tip

The tip is usually heavy and bulbous. It is thinned and elevated by dividing the medial crura and suturing them in the midline. Often a septal strut implant is placed in the columella to increase the tip projection. The subcutaneous fat tissue in the tip is trimmed, and sometimes the lateral crura are radically reduced or even completely excised. This combination of techniques serves to thin the tip while projecting it ideally above the nasal dorsum.

The Nostril

The flaring nostrils are reduced by a full thickness lateral excision of the alae. This is done about 1 mm from the true nasolabial fold so as to preserve this crease.

This approach using a bone implant in the bridge, a cartilage strut in the columella with approximation of the medial crura in the middle, and reduction of the nostril flare, has given better results than previous procedures.

Illustrative cases and drawings will be presented.

PERSONAL TECHNICAL MODIFICATIONS IN AESTHETIC SURGERY OF THE NEGROID NOSE

RIBEIRO, L.; BACKER, E.

The authors relate their experience in treating the negroid nose, and comment on technical changes considered as essential for this type of nose.

1.º) **Dorsum.**—The cartilage and bone grafts have been discontinued, since they become tortuous or suffer absorption in the postoperative period. They use a method of fixation of silicone prosthesis previously shaped, thus avoiding the frequent displacements of these prostheses, where usual techniques are employed.

2.º) **Tip.**—For this surgical stage, they use Serson's technique.

3.º) **Columella.**—Generally in the negroid nose the retracted colomella is one of the most difficult problems. The authors either displace the septal cartilage toward the base of the columella which becomes more protruding or implant sponge silicone.

4.º) **Treatment of ala nasi.**—This is the mean stage of surgery and the authors advise treatment without external scarring. It consists of:

- a) Subdermic displacement close to the nose area.
- b) Incision and resection resembling a half-circle at the base of the nostril close to the columella, through which the above-mentioned displacement is done.
- c) Suture of one «ala» to the other above the columella with elastic silicone thread.

The advantage of this thread is its elasticity which follows the movements of the nose «alae» without cutting the sutured tissue.

A PROCEDURE FOR ADVANCEMENT OF THE NASAL TIP

DUARTE CARDOSO, A.

In many cases of rhinoplasty it is necessary to advance the nasal tip.

It is possible to produce this effect using a procedure similar to Z-plasty, where the central line of the Z is located in the membranous or mobile septum, one of the triangular flaps is represented by the junction of the caudal and anterior edges of the septal cartilage and the other triangular flap is obtained in the full width from the columella.

When the triangular flap of the columella is transposed above the anterior margin of the septal cartilage, the antero-superior angle of the septal cartilage takes its place in the opening of the columella. With this Z-transposition the tip of the nose is advanced and the bridge of the nose shortened.

It is a Z-plasty with unequal flaps: the septal flap has 90° and the columellar may change from 30° to 45°. In such Z-plasties the advancement varies from 41% to 55% of the length of the central line. This is the reference that the surgeon must have in mind when using the procedure described.

DEFLECTION OF THE ANTERO-CAUDAL PORTION OF THE NASAL SEPTUM: ITS SURGICAL TREATMENT

FRANCESCONI, G.; FENILLI, O.

The surgical treatment of the deviated septal cartilage of the nose in this area is a rather hard problem to solve. The simple reposition of the cartilage in the vomer groove, as well known, may be sometimes fallacious, because the cartilage acts like a spring.

To improve the surgical result several methods are suggested. After having discussed the various techniques recommended by Joseph (1932), Blair (1932) and Holmes (1959), the authors suggest suturing the septal cartilage to the ventro-caudal nasal spina, passing the suture through a bone hole made in the premaxillary area.

CORRECTION OF PINCHED, DROOPED AND SADDLE NOSES IN RHINOPLASTY COMPLICATIONS

BOHMERT, H.

The reasons for these complications are listed and analyzed. The necessary surgery that should be done to correct the existing conditions and to improve the shape, contour and functions of the nose is outlined.

A common cause for rhinoplasty complication is a characteristic saddle nose disfigurement: a depression of the cartilaginous bridge with an apparent bony hump, due to a too extensive resection of the septal cartilage. The repair of cartilage depressions of a small size has been achieved by implantation of septal cartilage and with excised portions of the upper zone of the lateral crus of the lower alar cartilages. Depressions of a larger size following excessive removal of the dorsal hump require the insertion of a graft of costal cartilage or bone. Because of the disadvantages of cartilage grafts, the tendency to curl or twist, iliac bone grafts have been preferred for correction in the cases presented. The nasal bones are freshened, so the grafts can come in contact with them, preventing the tendency of absorption. Pinched noses, caused by too much resection of alar cartilage and vestibular lining, present difficult secondary corrective problems. A pinched and drooping nose with vestibular stenosis has been corrected by removal of the fibrous tissue and by cartilage grafting in the tip and columella, using the butterfly cartilage graft. The different steps of this operation are illustrated with diagrams and photographs. The surgery as suggested in the paper has given satisfactory results.

REPAIR OF SADDLE-NOSE

BRUCK, H. G.

Saddle-noses comprise only 4.3 per 100 (225 cases) in our personal experience of rhinoplasties. The deformity however is very conspicuous and frequently combined with respiratory troubles.

With the exception of SMR-deformities, most frequently the bone is involved, cartilage taking second place whilst the skin is usually intact.

For repair either local tissues, free cartilage grafts from ear or septum and autologous bone-grafts from the iliac crest have been used. (Bone-grafts in 174 cases.) The personal experience with alloplasties or heterologous bone-grafts was entirely negative. These implants were never introduced by ourselves but quite frequently removed after implantation somewhere else.

Precautions in the use of autologous bone to avoid later resorption are as following:

- 1) The graft must have bony contact on both ends and as much of it along its edges as possible.
- 2) The graft must be completely covered with mucous membrane to avoid infection and resorption.
- 3) It should leave the nasal tip out (the term «L-shaped» is misleading. Boomerang-shaped would come closer to its actual form).

A mobile, soft and narrow tip is obtained in this way, which does not interfere with facial movement.

The advantages of autologous bone-grafts are:

- 1) They can be used in complicated, even slightly infected cases (nasal dermoids).
- 2) Other rhinoplasty procedure like narrowing the tip, the base, moving the remaining nasal bones, etc., can be performed in one act.
- 3) A broken bone-graft can often be reset and will heal as the normal nasal bone would.

These advantages seem to outbalance the scar due to the incision on the hip by far and our own experience for the last 17 years has been so favourable that we still stick to this technique.

INDICATIONS FOR AUTOGENOUS SEPTAL CARTILAGE IMPLANTS FOR LOWER DORSUM DEFECTS IN CORRECTIVE RHINOPLASTY

BEERS, M. D.; VALIULIS, J.

The implanting of small autogenous cartilage implants of septum in the correction of small defects of the lower nasal dorsum as an adjunct in aesthetic corrective rhinoplasty procedures is presented and extends over a 20-year period of application.

The use of autogenous septal cartilage implants and grafts to the nasal dorsum in corrective rhinoplasty procedures is well documented and is a recommended procedure in the literature. The distinct advantages and application of such grafts in the routine corrective rhinoplasty have not been emphasized in the literature. The use and indications for such grafts are presented in this paper.

At the termination of surgery, in some cases of routine corrective rhinoplasty the transition of the thick skin of the alar area with the thinner skin of the lower dorsum may often produce an undesirable crease or aesthetic defect which can be easily corrected at that time by the insertion of a small autogenous septal cartilage implant along the lower midline dorsum to eliminate the defect and also to avoid the development of supratip deformities. This problem may occur especially in the seborrhic type of nasal skin. Other indications consist of the use of small grafts in cases of diffuse subcutaneous nasal scarring, bifid nasal tips, and when overcorrection of the septum excision along the dorsum may require immediate correction.

The results of the clinical application and technique are discussed as well as the long term results. No complications per se have been encountered in the application of this procedure. The technique and the results achieved are demonstrated by photographs.

TOTAL REMOVAL OF THE SEPTUM IN RHINOPLASTY FOR THE CROOKED NOSE

A REPORT ON EXPERIENCES WITH EIGHT PATIENTS

MORGAN, B. L.

One of the major problems in rhinoplasty in those noses that are deviated to some extreme, to one side or the other, is the problem of midline repositioning. The difficulty has always arisen because of the associated deviation of the septum and the difficulty in correcting the curvatures which are inherent in the septal malformation. Over the years, there have been many methods used to try and overcome this problem. The most recent has been dicing of the septal cartilage. In several cases, in the author's practice, when this problem was found in male patients, his solution has been to do a total removal of the cartilagenous septum. The lateral cartilages have been left intact and the dorsum of the lateral cartilages has served instead as the bridgework between the bony framework and the tip and no secondary saddle deformity has been seen. Some of these cases now have a follow-up for as long as three years.

The paper is illustrated by line drawings showing the technique and by pre- and postoperative photographs of the patients. This method is offered as an alternative method of treating these deformities and its applicability is limited to those patients who have well-developed lateral cartilages.

WHEN IS A SEPTAL CORRECTION NECESSARY IN AN AESTHETIC RHINOPLASTY?

WILLEMOT, J.

Everyone agrees that a septum has to be rectified when there is a functional disorder accompanying the aesthetic damage. People forget often that there are some **absolute** indications for septoplasty during a few aesthetic rhinoplasties:

- deviation of cartilagineous pyramid,
- deviation of osseous pyramid not perfectly rectified by the osteotomies or when the septum does not follow the rectification,
- saddle nose only caused by septal luxation.

There are **relative** indications for septoplasty.

- when the septum is used as an approach
 - for a way to elevate or lower the profileline
 - for material to obtain a small graft.

NASAL OBSTRUCTION POSTRHINOPLASTY

MODESTO, D.

With relative frequency patients are submitted presenting difficulty in breathing after rhinoplasty. They can be divided into three groups:

1st.—Patients with constriction of the nostrils after rhinoplasty.

2nd.—Patients with adhesions at the nostrils.

3rd.—Patients with normal dimension of the nostrils in which the shape of the nasal pyramid was modified (the tip raised, a deviation corrected, etc.).

In the two first groups the respiratory difficulty is due to a mechanical obstruction.

In the third group, of which we selected 8 patients for study, and in which the nostrils show a perfect permeability, a septum deviation and crest at the anterior region of the septum were present, which did not produce any symptomatology before rhinoplasty but became an obstacle to the air passage after surgery.

When we reproduced the preoperative condition, breathing became easier.

This suggests that the direction for air passage had changed, being impaired by the septal crest.

It is a common fact that some patients with severe septal deviations do not present breathing difficulty while others with more moderate deviations complain of great breathing difficulties.

We have reproduced transparent plastic substances and wax molds with different types of nostrils, of nasal pyramids and septal cartilages and verified that the air passage changes greatly when nasal pyramid is modified (for example by raising the nasal tip).

Therefore, any of these modifications may produce breathing difficulty, the patients being unsatisfied despite of a good aesthetic result.

This is illustrated with drawings and photographic material. A careful preoperative examination in order to obtain a good aesthetic and functional result is recommended.

THE NON-CLEFT «HARE-LOOK»

WILKIE, T. F.

Occasionally a patient is referred to a plastic surgeon for advice concerning asymmetry of the nose and upper lip of the type usually seen only with a repaired cleft («Hare») lip, and palate. Examination shows, however, that the lip and palate are intact. There is no history of an operation and there is no surgical scar. Their appearance is therefore a «non-cleft hare-look».

These patients are not as uncommon as formerly thought. Two articles on this topic recently appeared in the same issue of a plastic surgery journal bringing the total of recorded cases, suddenly, from three to nine.

Rationale for treatment:

Eric Peet taught that «a good scar is acceptable if the form is normal». Gillies taught that anatomical parts should be placed in their proper positions.

Replacing the slightly abnormal lip elements into their normal positions requires medialwards advancement of the lateral element and downward rotation of the medial element (philtrum), as described by Millard.

The depressed nostril, ala, and nasal tip can be corrected by medial advancement of the alar base, and upward rotation of the split columella, as described by Gillies and Kilner.

These two procedures are similar and can be combined into a single operation in old cleft lip cases requiring aesthetic revision of nose and lip.

This paper includes a case report in which a «non-cleft hare-look» patient was successfully treated according to this plan.

The «non-cleft hare-look» patient has now been firmly established as an entity. An operative design and a case report have been presented to suggest that being fair to these patients probably means operating on them.

THE TREATMENT OF PROMINENT EARS WITH A PARTIAL CHONDROTOMY METHOD

BRAVO, N. E.

This surgical procedure consists of a partial chondrotomy by two parallel incisions to reform the antihelix. With these two incisions we produce a weakness of the cartilage, which provides a means of obtaining a more natural and delicate antihelix.

Then we place 3 or 4 stitches in U-form outside the incision lines and the folding of the cartilage takes place, graduating the required degree of folding.

For major security and to avoid recurrence of prominence, we place Malbec's orthopedic stitches to keep the auricle in good position.

For the concha's treatment we carry out partial chondrotomies according to Fernández, with no resection of the cartilage.

We have operated on around 380 cases with this technique since 1969, with satisfactory results and with no recurrency.

RATIONAL OTOPLASTY SIMPLIFIED

WILKIE, THEODORE F.

This paper describes a new modification of the mattress suture technique which combines the advantages of increased simplicity and decreased tendency to complications. It is modified after Mustardé, Kaye and Mouly in that several permanent mattress sutures are placed in the cartilage to create and maintain the normal fold. These sutures, when applied properly, will produce a normal appearing ear in most cases, the minor excesses of conchal cartilage being folded back as part of the antihelix. (A few ears require excision of a strip of conchal cartilage in addition to the procedure described.)

The new modification is simple to perform and correct folding is assured. Anterior cartilage weakening is carried out to aid the folding of the cartilage and posterior undermining of the skin is done to help maintain the folded position by formation of scar tissue adjacent to the posterior aspect of the cartilage in addition to protecting the posterior skin during placement of the mattress sutures.

The incision is posterior (out of sight) and small (minimizing keloids), but allows mobilization of the cauda helicis with the lobule, so that these structures can be placed posteriorly. No sutures need to be placed anteriorly and the small posterior incision can be sutured with fine chromic gut, which does not require removal.

A COMBINED TECHNIQUE FOR THE CORRECTION OF PROMINENT EARS

ELLIOTT, R. A.

Dissatisfaction with the results of otoplasty using any one of the popular methods has stimulated the evolution of a variable technique which combines salient features from several of these methods. Elements of the operative techniques of Mustardé, Stenstrom, and Furnas have been fused to afford an operative approach which emphasizes: (1) construction of the antihelix; (2) positioning of the lobule; and (3) positioning of the concha.

The goals of aesthetic otoplasty will be discussed. Representative cases will be shown to demonstrate the common types of prominent ears, the author's approach to their correction, and the results.

CORRECTION OF THE PROMINENT EAR

GEORGIADÉ, N. G.

The author describes his experiences utilizing a posterior and anterior subcutaneous approach with emphasis being placed on the correction and the avoidance of the usual pitfalls with previously described techniques. Diagrams and illustrations are used to bring out the essential points considered necessary in the construction of an aesthetically pleasing ear. A series of 104 ears is the basis for techniques described.

TWO ANTERIOR APPROACHES FOR THE REDUCTION OF PROMINENT EARS

WALKER, H.

For many years it has been traditional to approach the surgical reduction of prominent ears posteriorly. Amongst the disadvantages of this are the necessity for complete surgical penetration of cartilage, risk of damaging the anterior skin as the cartilage is incised, hazards of undermining of anterior skin from the posterior approach, difficulty in controlling bleeding anteriorly between cartilage and skin, possible increased incidence of haematoma formation anteriorly and limited access if accurate parallel scoring is required to divide the anterior layer of perichondrium. If the fear of unsightly scarring by the anterior approach can be overcome, all the above-mentioned hazards and difficulties should be minimised and access to the perichondrium for parallel scoring should be much easier and safer. An anterior approach does not preclude the excision of cartilage and may make posterior excision of a skin ellipse more expeditious and safer. An anterior approach has been used, both peripherally under the curled rim of the pinna and by a concentric incision between the rim of the pinna and the external auditory meatus. The results are surprisingly free of aesthetic disadvantages.

RADIOLOGICAL POSSIBILITIES IN THE FIELD OF AESTHETIC-PLASTIC SURGERY

DELGADO SIMONI, F.; GONZALEZ-ULLOA, M.

As opposed to the noticeable advances in aesthetic-plastic surgery in the last twenty years, radiology has not contributed any thing new to this field.

We think that a scientific methodology for the surgical planning in patients to be operated on can only be achieved through radiological studies, which simultaneously allow the bone structure and the soft planes to be studied, thus obtaining the millimetric exactness required for this type of surgery.

This has been the goal of many radiologists for a long time, and to accomplish it, several techniques - some complicated, artificial, geometrically distorted and unpractical-have been tried out.

We have developed a technical principle by which the requirements mentioned can be obtained in one plaque, without photographic or darkroom tricks, with almost isometric precision obtained in only 90 seconds.

The theoretical principle of this technique is to use low milliamperage with high kilovoltage, non-screen film, 200 cms. distance film-focus and automatic ninety seconds development.

We have named this technique «bustography» (from the latin bustus = upper part of the body—from shoulders upwards). Obtained at profile projection, it allows the evaluation of elements as thin as the human hair.

By applying this procedure to other regions of the body, we have obtained **torsographies** (trunk area), **tempograms** (temporal region), **melographies** (malar area), and sectional profilegrams of practically every area of the body - many unappreciated before.

We consider that, based upon this new radiological application, a new field has been opened by which aesthetic-plastic surgery can continue this era of precision and absolute objectivity.

FACIAL WAX CAST: AN ELEMENT FOR PREVIEWING THE RESULT OF AESTHETIC CORRECTION

REGINATO, L. E.; FLAQUER DA ROCHA, R.

In plastic surgery there are many ways to evaluate facial deformities and to plan their correction: photography, drawings, cranio-metric measures, facial casts, etc. These methods do not furnish exhaustive data for an objective prevision of the results, both for patient and surgeon.

The following method is used by the authors:

1st. With flexible material (alginate) a moulage of the patients face is made and used for obtaining one or more wax casts.

2nd. Working on this wax cast, still in plastic phase, the further surgical corrections can be performed:

a) Nasal correction: correction of the dorsum and of the shape of the tip.

b) Chin reduction and increase by modification of the chin projection.

Further research may extend its use for other purposes in aesthetic plastic surgery of the face. It also offers the patient the possibility to give his opinion during the preoperative planning and to appreciate the possibilities and limitations of the surgical treatment.

The method is a useful guide permitting the evaluation of further surgical steps when pre-established results are taken into consideration.

THE GOLDEN PROPORTION AND BEAUTY: ITS PRACTICAL APPLICATION

LONGACRE, J. J.; SEGHERS, M. J.

The reconstruction of a deformed human face is not a free and improvised art, based on feelings or impressions; on the contrary, it is an art strictly tied to and developed from the laws of geometry. We will present the golden number and the golden proportions as they have been known since the times of the pharaohs. Their artistic, aesthetic value and also their history will be briefly outlined. Some applications to the proportions of the human body and mainly to the study of the face will be presented. Jointly with the data furnished by the study of the profiles, the ideal facial rectangle should serve as a starting point for the setting or the resetting of a normal facies. Typical cases are introduced showing the practical application of harmonic analysis and the result attained.

For each ethnic group there is an underlying bone structure which determines whether or not that individual is to be considered handsome. The more the plastic surgeon takes these facts into consideration, the more pleased will his patient be with the result.

PROFILEPLASTY: STANDARD AND NEW PERSONAL TECHNIQUES

HINDERER, U. T.

The techniques used by the author to achieve a harmonious facial balance are described. Among the techniques of other authors, the correction of the nasal tip according to Serson and the lateral osteotomy according to Schrudde-Olivari, as well as the method of Pitanguy for chin augmentation are preferred. A chisel for the transverse osteotomy, designed by the author and used for the improvement of a prominent radix nasi, as well as various personal techniques for the correction of the different facial segments in profileplasty are described:

- The use of Gibson and Walker's technique for the treatment of osteomata and frontal sinusitis for the aesthetic correction of the protruding lower frontal segment.
- The Z-plasty of the upper part of the transfixion incision for prevention as well as for treatment of a drooping nasal tip.
- The procedure to lengthen the upper lip, too short when in motion, by means of sectioning of the m. depressor septi nasi and subperiosteal insertion of Kiel-bone graft close to the spina nasalis anterior.
- The technique for augmentation of a flat maxillary region by means of subperiosteal insertion of Kiel-bone graft through an intranasal incision at the level of the apertura piriformis.
- The technique for augmentation of the zygomatic regions in order to improve the facial oval, achieving «higher cheek bones» by means of inserting Kiel-bone grafts through an incision 1 cm. laterally and below the lateral canthus (in direction of the RSTL), through the lower palpebral incision of a simultaneous blepharoplasty or through a rhytidectomy incision.
- The technique for treatment of microgenia with simultaneous double chin by means of a dermis-fat flap based on the area adjacent to the mandibular border, which is subcutaneously buried in inverted position in the mental region.

The convenience of performing, in certain cases, a profileplasty combined with the treatment of the aging syndrome is commented on as well (rhinoplasty, blepharoplasty treatment of the wrinkles of the upper lip by means of chemical peeling combined with our technique of subcutaneous temporal implantation of silicone sheet, etc.).

QUANTATIVE METHOD OF PROFILEPLASTY

DE STEFANO, G. A.

Beauty is not constant nor absolute. Human faces are all similar yet differ in many respects both within and beyond the normal standard. Many inherent and acquired factors influence the facial pattern and all must be considered to give the face a harmonious balance. The Frankfurt plane and its perpendicular, the facial plane, are utilized as standard norm. The facial and mandibular planes, including the mean normal angle, are superimposed upon the cephalometric radiograph of the abnormal face, with proper rotation discrepancies measured. The exact site and size of autogenous bone grafts or alloplastic material needed for the augmentation or reduction are determined.

INDICATIONS FOR COMBINED OPERATIONS IN AESTHETIC PLASTIC SURGERY OF THE FACE

LUZ, S.; ACOSTA DE ALMEIDA, D.; LION, P. M.; FRANCO, T.; REBELLO, C.

Considering that every segment of the face is an important part in the overall appearance, the authors recommend a detailed observation of the whole face and its various components even when only one detailed area is concerned. The influence of one part of the face on the others justifies that a complementary operation be suggested to the patients whenever necessary.

The final decision belongs to the patient but the advantages of an associated operation must be considered.

Some cases are shown.

FACIAL CHANGES FOLLOWING COMBINED OPERATIONS

SZPILMAN, M.

Art being the constant companion of the plastic surgeon requires of him not only the technical capabilities, scientific knowledge, but also aesthetic taste which together with personal experience will offer the patients better possibilities in their search for improvement. Sometimes, however it is impossible to reach the canons of beauty which one would like to attain.

The possibility of bettering someone's life by improving his appearance through combined operations on the face is valid in the sense that it may give or restore a sense of well-being, self-confidence, and a new animation for life, professionally and sentimentally.

We feel that the surgeon will not only reconstruct the physical side but the emotional as well. Objections may arise from some quarters; these may be people that cannot understand the dissatisfaction of others who feel handicapped through their own impressions and reasoning. Values are different for different people and we also feel that these problems are personal and deserve personal solutions.

Preoperative Analysis

Many of the patients that look for a plastic surgeon cannot be precise about what they want. Sometimes their concepts are far from reality but they always can say they want to «improve», not really knowing how.

Obedying the artistic and technical principles, we plan carefully through the study of actual conditions and possible solutions with a combination of operations. This study includes: physical examination, psychological conditions, apparent age, profession, etc. Casts, drawings, schemes, photographs and films are made together with the artistic planning. If necessary, some steps are taken such as weight increase or reduction, and bettering of other conditions such as skin status, etc. The filming of facial expressions furnishes a good element for study.

MAXILLARY OSTEOTOMIES IN PROFILE RESTORATION

QUETGLAS, J.

The plastic surgeon is often required to restore the harmony and beauty in the facial profile. Sometimes the malformation is so important that it is necessary to make osteotomies of the mandible or/and the maxilla to correct it. These malformations may be due to micro-or macrogenia, micrognathia, mandibular prognathism, maxillary retrusion, and so on.

In this paper we consider several cases of macrogenia, mandibular prognathism and maxillary retrusion as congenital malformation.

Before concluding the type of operation to be done, we consider the X-ray cephalometric study and also the photograph and dental cast study. We consider as one of the most important studies, the dental cast mounted on the Hanau dental articulator and used to simulate the osteotomy which is planned.

In macrogenia we use, when possible, the horizontal osteotomy, by the «degloving» technique, of the inferior border of the mandible and chin.

In the true mandibular prognathism we use the vertical osteotomy of the ramus of the mandible by external incision below the angle of the jaw. After the osteotomy, the mandible is displaced backward and the fragments immobilized in a good position by stainless wire osteosynthesis. The correct dental occlusion is maintained by intermaxillary fixation.

In cases of maxillary retrusion with malocclusion, we use a horizontal osteotomy of the maxilla and the hard palate to gain a dento-alveolar advancement and to reestablish the correct occlusion.

In a few cases a combined deformity is present. A mandibular prognathis is combined with a maxillary hypoplasia. In such cases it is necessary to do a complex operation adding to maxillary osteotomy, an osteotomy of the vertical ramus of the mandible. The correct dental relationships are maintained by intermaxillary wiring to the previously attached appliances.

Generally these patients want a corrective nasal aesthetic plastic operation to achieve the complete restoration of the profile.

HYPERMENTONISM

MORAES DE AVELAR, J.; GARCIA, L. C.; AURELIO, M.

We consider hypermentonism, the condition where the dental occlusion is normal and the augmentation of the mandibular segment is due to the hypertrophy of the bone located in the chin.

TECHNIQUE

This surgery is undertaken through an incision above the gum lip channel and a dissection under periosteum. A bone resection based on the cephalometry should have a shape to harmonize with the aesthetic shape of the chin. A Pitanguy's flap with superior irrigation is shaped at the median raphe region and then turned over 180° to be attached above the previous level.

When the patient so desires, we can, by separating muscular groups, shortening and tractioning the raphe, prepare a small median fossa with a graceful aspect.

These methods can be used in case of a false hypermentonism, having hanging chin, characteristic of some patients with advanced age, where the rotation given to the flap lifts and maintains the muscles.

The dressing is done with strips of adhesive tape, centralized by the raphe, in order to diminish the edema and the formation of dead spaces.

SURGICAL TREATMENT OF BALDNESS USING TWO PARIETAL FLAPS

JURI, J.; ARUFE, H. N.; MIRA, C. E.

The authors present a new solution for the treatment of Hypocratic baldness in man.

They classify the different degrees of baldness according to its extension and revise the methods used until now.

They explain details of the new technique which consists of using parietal flaps on both sides. The flaps include the temporoparietal nerves and vessels in their pedicle. The flaps are then transposed to the anterior alopecic zone, and are then closed by advancement and suture of the borders of the corresponding donor sites.

They offer their experience on the basis of 132 cases operated on and the results obtained.

NEW ASPECTS IN FREE SCALP TRANSPLANTS

COIFFMAN, F.

At the present time, free autotransplantation of the scalp constitutes the most effective form of treatment of permanent alopecias, regardless of their etiology. It is estimated that since Prof. Norman Orentreich, of New York University, popularized the method of punch-scalp autografts ten years ago, almost 200,000 patients have undergone this treatment.

This treatment essentially consists of taking small cylinders of scalp (without adipose tissue) from the posterior and lateral regions of the head, and transplanting them to the alopecic zones, generally to the anterior and coronal regions, of the same patient. Each cylindrical graft is usually 4 millimeters in diameter and contains an average of 15 hair follicles. The author prefers large series transplants, 100-150 grafts, rather than repeated small sessions. The surgical interventions, performed under local anaesthesia and in ambulatory form, are usually spaced an average of three weeks apart. Generally, three operations are sufficient. Usually all the grafts take, but only 70 % of the follicles actually produce hair. This hair begins to grow approximately three months after the operation. Edema of the forehead, very frequent in large series transplants, pain, and the necessity of using a hat if the patient does not initially have enough hair to cover the grafts, are inconveniences which may bother the patient.

The author describes the technique and instruments used, many of which are original.

In a study of 120 biopsies taken male patients with seborrheic alopecia, the author compared normal scalp zones with alopecic zones and found differences which are commented on.

NEW TECHNIQUE FOR TREATMENT OF COMMON BALDNESS BY SCALP AUTO-GRAFTS

AROUETE, J.

Scalp auto-grafting is a difficult operation because of bleeding. Two new instruments «Haemostats for scalp grafts» allow bloodless operations. The «occipital haemostat» has the shape of a frame, with a pneumatic bladder on one side. It is held on the head by a frontal strap. The «frontal haemostat» is placed around the head like a circular tourniquet.

Concerning the excisions of the grafts, the usual instrument «punch» is not easy to handle and does not allow accurate incisions. A new instrument called «round knife for scalpgrafts» is proposed. This instrument is composed of a floating bearing surface on the opposite end of the knife. This bearing surface facilitates the complex movement of the incision which must be perfectly performed in order to obtain good results.

ABDOMINAL DERMOLIPECTOMY - A GEOMETRICAL APPROACH

SERSON, D.

The author presents experience in abdominal dermolipectomies through a technique which has been employed for several years.

The excess infra-umbilical tissue is excised in mono-block after demarcation of a geometrical design, and the abdominal supra-umbilical tissue flap is slipped over the umbilicus and is then sutured into the inguinal fold. A slit is made in the flap to draw out the navel in its new position.

Special emphasis is given to the plicature of the abdomen's straight anterior muscles fascia, in longitudinal and horizontal direction, and to the placement of the final scar, on the inguinal fold.

ABDOMINAL DERMO-LIPECTOMY MODIFIED INCISIONS

REGNAULT, P.

A short review of the usual main techniques used is given for comparison and shows the evolution of ideas over the years.

The operative technique which has been performed by the author for several years in a large number of cases, offers some different characteristics. The lower incision is very low and appears like a lazy W so that the traction on the upper flap is equalized over the middle third of the total length. The umbilical incision has a marquise shape which avoids the possibility of later circular retraction and which fits well into a transverse linear incision in the flap. The undermining is extended up to the 6th rib. The excision of skin and adipose tissue is made along the shortest straight lines. The closure and early postoperative care are made very much easier by the position of the patient. A drainage and moderate pressure are used to avoid any chance of hematoma. The technique has been used in a great number of varied cases and especially in association with ventral hernias. In some cases a marlex mesh has been inserted to reinforce the abdominal wall with later fibrosis.

The results have been excellent from the functional and aesthetic points of view. Very small bikinis can very easily hide the scars. Only a very small percentage of cases required a scar revision due to hypertrophic scarring or widening of hypotrophic scars. Only 2 cases presented small sloughing in our series; they were caused by fluid collection and overdistension of the flap. They were both closed after secondary excision.

ABDOMINOPLASTY THROUGH SUBMAMMARY INCISION

REBELLO, C.; LION, P. M.; FRANCO, T.

The incision of almost all transverse abdominoplasties is placed in the lower abdomen, close to the lower limbs and the subsequent resection reaches only the lower part of the abdomen.

The upper abdomen improves only by traction and only in rare cases is a slight defatting performed in this region.

Considering that some patients have a more predominant dysmorphism in the upper abdomen, the authors developed a segmentary resection in this region through a submammary incision.

A case was operated on in which the very patient himself suggested this approach. Surgical details and results are shown.

While only one case has been operated on, the authors think that this line of operation may be used on those patients presenting the described pathology and who have been or are going to be submitted to a mammoplasty.

A secondary resection placed in the lower abdomen may be performed at the same time or in a subsequent operation.

The segments to be excised may be used as a dermo-fat flap to rebuild a hypotrophic or atrophic breast.

LIPEXHAERESIA IN THE CORRECTION OF LOCAL ADIPOSITAS

SCHRUDDE, J

Lipexhaeresia has been applied by us since 1964. This procedure makes it possible to correct local adipositas without excessive scar formation. Three regions lend themselves well for this intervention:

1. The external region of the thigh.
2. The inside of the knee.
3. Adipositas of the calves.

The technique is the same for all three regions. The extent of the fat tissue to be removed is marked prior to the operation. From an incision not exceeding 2-4 cm a subcutaneous tunnel is created, large enough to allow the introduction of the curette. Curetting is performed first laterally, then into the depth, and finally towards the skin surface. Subsequently the fat is squeezed out through the incision. To assure an even removal of the fat, the inside of the pocket is controlled by inserting the finger.

Special remarks regarding the different regions:

In the trochanteric region the horizontal cut is placed high, even if the surgical approach is lengthened, in order to assure sufficient covering by a bathing suit.

The incision in the knee region is horizontal and below the tuberositas tibiae, for aesthetic reasons. This incision allows also the removal of pre-tibial fat.

In the lower leg the incisions run vertically and on the inside as well as on the outside. This prevents, in the case of extensive lipexhaeresia, disturbances of the dermal blood supply. The procedure should be performed in two sessions, starting with either side.

The intervention in the knee region can be done under local anesthesia in the outpatient department. Interventions in the other two regions require hospitalization, because the lower leg should be kept elevated. The thigh must be drained on account of serous accumulation.

OHMORI, S.; HIRAYAMA, T.

We have had experience in treating several kinds of deformities by using silicone compounds. We used the following compounds in cases presenting the following conditions:

RTV (Dow Corning) 5392 was used for narrowing the pharyngeal wall on 14 cases which showed the phonation of nasal escape type. RTV5392+silicone fluid (350cs) were used on 1 case of aplasia mammae, 1 case of pectus excavatus, 3 cases of morphea, 2 cases of indented scar. Phycon 6600 (Fuji Polymer) was used on 6 cases of breast augmentation, 5 cases of hypoplasia mammae, 1 case of aplasia mammae, 3 cases of deformities of the chest wall, 2 cases of morphea, 6 cases of hemiatrophia faciei, 6 cases of indentation caused by scarring. Phycon 6600+silicone fluid (350 cs) were used on 4 cases of breast augmentation, 3 cases of hypoplasia of the breast, 1 case of hemiatrophia faciei, 1 case of indentation caused by scarring, 1 case of glabellar indentation.

Silicone fluid (350cs, Fuji Polymer) was used on 1 case of morphea, 12 cases of hemiatrophia faciei, 3 cases of indentation caused by scarring, 5 cases of asymmetry of the face caused by 1st and 2nd branchial syndrome, 1 case of glabellar indentation, 7 cases of indentation found on extremities, 2 cases of soft tissue atrophy of the extremities, 5 cases of wrinkle formation on the face.

The authors tried to perform experimental studies to find out if the injected RTV or silicone fluid produce a tissue reaction or what happens if those substances are injected intravenously.

Also the authors tried to check up whether the adjuvant disease is induced or not when those compounds would be utilized in the tissue of the human being.

From the above mentioned experiences the authors summarize the effect of silicone compounds as follows: as far as RTV is concerned, this substance seemed to be considered suitable for moulding a desirable round shape of the breast, but it tends to change into a hard lump as time goes by if the injected amount is more than 10cc at one time. For the treatment of facial hemiatrophy the authors think the injection of silicone compound, especially the fluid type, is one of the best choices for treatment.

CONNECTIVE TISSUE REACTION TO POLYSILOXANE. PATHOLOGICAL CONSIDERATIONS

VARGAS DE LA CRUZ, J.

Foreign bodies in the human organism produce a reaction in tissues, especially in connective tissue, which varies according to several factors such as: antigenic activity, physical or chemical disintegration, bacterial or viral contamination, etc.

Polysiloxane in a pure state, is a thick fluid, inert and viscous, which produces a foreign body reaction very minute indeed, causing microvesicles described previously by the author and which functionally behave in a similar fashion to adipocytes.

The normal phenomenon consisting in transformation of the undifferentiated cell in adipocytes, is copied by means of the introduction of polysiloxane in macrophages through their phagocytic function.

The evolution of macrophages and the microvesicles is studied experimentally by histological slides.

COMPLETE DEBRIDEMENT, STRIPPING AND DISSECTION OF THE LEGS BECAUSE OF INCLUSION OF INORGANIC MATERIAL

GONZALEZ, R. A.; OJEDA, F. X.

This surgical technique is designed to completely strip the surface of the legs following injection of inorganic material (silicone and/or other).

The clinical evolution is evaluated and the area where inorganic material exists is defined by X ray.

The territory of the internal saphena vein is determined, the levels are separated and dissection of the affected tissues is carried out. These can be considered to be of three types:

- 1) Granulomatous tissue.
- 2) Reaction to the foreign body.
- 3) Infiltrated tissue.

The operations have achieved satisfactory results, reducing the oedema and appearance of objective signs in the repeated process of recurrent infection.

SURGICAL ABRASION OF FACIAL SCARS: A 20-YEAR FOLLOW-UP

GLANZ, S.

With modern automobile high speed transportation and resulting accidents, some of the most common injuries treated by plastic surgeons are the post-traumatic disfiguring facial scars and their sequelae.

The author presents a number of modalities of surgical abrasion that have proven very valuable in facial scar therapy for over 20 years. An evaluation of various methods is discussed with pitfalls of therapy and how they can be avoided.

An explanation of time lapse from date of injury to surgical resection and then abrasion is presented.

Surgical resection prior to abrasion is indicated when necessary for a change in scar direction, camouflage of obvious defects, and correction of distortion from kinetic areas. The time-honored methods of Z-plasty, V-Y maneuvers and rotation flaps are briefly mentioned as an empirical skill.

Utilization of abrasion methods following skin grafts is also described with satisfactory results.

Types of skin and indications not amenable to abrasion are categorically described and related to age and sex of patient. The most acceptable type of skin for abrasion is mentioned.

Factors of skin thickness, anatomical location of scar tissue, and distribution of scar aesthetic facial segments are discussed with definitive indications for abrasions.

The technical method of surgical scalpel abrasion is explained as well as postoperative dressings and care with necessary follow-up treatment. Examples of specific cases are shown to depict what may be expected and most important, when complications occur, how they are best handled.

ROUND TABLE

«Present status and training in Aesthetic-Plastic Surgery; preservation and protection of the field of Aesthetic-Plastic Surgery with regard to scientific quality, ethical aspects and legislation of practice.»

Chairman: Lewis, J. R., U. S. A.
Co-Chairman: Hinderer, U. T., Spain
Secretary: Fredricks, S., U. S. A.

Participants: Berndorfer, A., Hungary
Bornstein, L., Israel
Caronni, E. P., Italy
Castañares, S., U. S. A.
Davis, J., Argentina
Dufourmentel, C., France
Gibson, E. W., Australia
González-Ulloa, M., México
Hueston, J. T., Australia
Kroo Boo-Chai, Singapore
Lemos, P., Brazil
Malbec, E. F., Argentina
Marino, H., Argentina
Matthews, D. N., England
Meyer, R., Switzerland
Mustardé, J. C., Scotland
Nieto Cano, G., Colombia
Sánchez Galindo, J., Spain
Schrudde, J., Germany
Serson Neto, D., Brazil
Spina, V., Brazil
Viñas, J. C., Argentina

FILMS

Beers, M. D., U. S. A.:	Subpectoral Breast Augmentation Procedure
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