the ala. A novel method of analyzing Mohs maps was created to examine directionality of positive margins.

MATERIALS AND METHODS: All patients undergoing reconstruction following primary BCC excision of the nasal alae were recruited through a single institution. Patient demographics, details of resection and reconstruction were recorded. Positive margins were scored using a quadrant-based directionality system. Defect size was classified as large or small stratified by median defect area. Fisher’s exact-tests were performed.

RESULTS: A total of 124 patients (63 male; 61 female) were included in this study. Mean age at time of surgery was 67 ± 12.7 years. Most patients required multiple levels for dermatopathological clearance (n=101, 81.5%). Directionality was found to be preferentially positive in the medial-caudal direction (n=22, 18%), medial-cephalad direction (n=13, 11%), and lateral-caudal direction (n=10, 8%). Median defect area was 0.81cm² (Q1: 0.55–1.5). Defect size significantly influenced reconstructive method (p<0.01). Small defects were commonly treated with secondary intention (n=24, 40%), while larger defects were reconstructed with nasolabial flaps and full thickness skin grafts (n=15, 25% and 22%). Follow-up time ranged from 0–87 weeks and complications were low (n =14, 11.2%).

CONCLUSION: Surgical margins are preferentially positive in the medial-caudal direction in the alar region. A negative margin in Mohs surgery is an acceptable method of ensuring oncological clearance in a sensitive cosmetic area, which historically has had high recurrence rates when treated without Mohs. Reconstruction under local anesthetic is safe and complication rates are low.

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Multiple Peripheral Osteomas Related with Frontal Exposure by Bicoronal Incision

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INTRODUCTION: The purpose of this presentation is to present the clinical features of a rare case of multiple osteomas most suspiciously caused by the activity of the periosteum in the exposed area by a bicoronal incision made ten years earlier.

MATERIALS AND METHODS: A 12-year-old boy presented with a complaint of swelling in the forehead. Tumors that were found, with a maximum size of 2.0 x 2.0cm, gradually grew during the following four years. The patient had a history of surgery for excision of foreign body in the intra-orbit ten years earlier. The hard bone-like tumors were otherwise asymptomatic. There was no history of similar findings within the family.

RESULTS: An histopathological examination showed four pathologically compact-type osteomas.

Osteoma of the skull is a benign slow-growing osteogenic lesion typically composed of well-differentiated mature bone tissue. It is characterized by the proliferation of compact or cancellous bone and is found almost exclusively in the head and neck region. Central, peripheral and extra-skeletal are the major variants of craniofacial osteomas. Trauma, inflammation, developmental disorders, and genetic defects are considered as their etiologic factors. Paranasal sinuses, especially frontal and ethmoidal sinuses, are the favorite location of peripheral craniofacial osteomas.

CONCLUSION: Peripheral osteomas are usually benign, innocuous lesions, but their size, prominence and visibility on the face necessitates a surgical intervention.1,2 We describe a rare case in which multiple osteomas were located in the frontal area likely related with an exposure of the site by bicoronal incision made ten years earlier.

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Nail Bed Defect Reconstruction Using Thenar Fascia Flap and Nail Bed Graft

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INTRODUCTION: Split-thickness nail bed graft is the most preferred treatment option for covering nail bed defects.1 However, full-thickness loss of nail bed soft tissue

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precludes direct graft placement because there is no vascular wound bed for the graft to take. To cover such exposed distal phalanx and provide a graft bed, we used thin thenar fascial flaps. In this case series, we present our approach to such refractory defects using a two-stage operation.

**MATERIALS AND METHODS:** Between 2014 and 2016, thenar fascial flaps and nail bed grafts were used in five patients. All the patients had full-thickness nail bed defects due to machines or door jamming incidents, and the sizes of the defects were more than half of the whole nail bed. We designed the flaps as general thenar flaps, performed suprafascial dissection, and elevated the dermal flaps proximally. We then performed subfascial dissection over the thenar muscle from the proximal to the distal direction and turned over the only fascial layer and inset onto the defects. After 2 weeks, the flap was divided, and a split-thickness nail bed graft was taken from the big toe. Tie-over dressings were performed, and the donor sites closed primarily.

**RESULTS:** All flaps survived completely, and all split-thickness nail bed grafts were well taken. The mean follow-up period was 11 months. Nail growth was observed to the end of the distal nail bed without non-adherence, and the overall shape of the new nail was symmetrical to the corresponding finger nail of the contralateral hand. Cosmetic outcomes were excellent. The big toe nail showed partial non-adherence initially, but improved with time. None of the patients experienced any other complications.

**CONCLUSION:** Full-thickness nail bed defects, especially with bony exposures, are difficult to operate with satisfactory results. The thenar fascia flap is extremely thin, yet performs admirably as a wound bed for split-thickness nail bed grafts. Morbidity is minimal at both the thenar and great toe donor sites. Functional and cosmetic outcomes are excellent. It could be an excellent treatment option for these kinds of cases.

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Nonexcisional, Minimally Invasive Rejuvenation of the Neck Using Radiofrequency Tissue Tightening

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**BACKGROUND:** Noninvasive radiofrequency (RF) and lasers have been used for skin tightening and body contouring since the 1990s. The safety, efficacy, and patient satisfaction with the procedure using a novel RF device (BodyTiteTM; Invasix Ltd, YokneamIlit, Israel) were evaluated.

**METHODS:** We retrospectively included 13 patients who were treated with the BodyTiteTM to rejuvenate neck skin from May 2012 to May 2014. The power of the device was set between 10 and 15W. The target temperature was set at 38°C. Three independent evaluators were asked to grade baseline and 6- to 12-month follow-up photographs using a comprehensive quantitative 4-point laxity grading scale. All patients were asked to rate their satisfaction with the aesthetic outcome and quality of life after treatment.

**RESULTS:** Grading results of baseline and follow-up photographs of patients were statistically significant with an average grade improvement of 1.01 points on the 4 point scale. Using a patient satisfaction scale, patients were also significantly more satisfied (poor, 0%; fair, 15%; good, 46%; and excellent, 39%). There were transient complications, such as minimal erythema, mild edema, and focal hardness, which resolved spontaneously within 1 week. There were no significant adverse effects or complications.

**CONCLUSIONS:** The BodyTiteTM is a minimally invasive, RF treatment that was demonstrated to improve skin laxity without significant adverse effects or complications. The BodyTiteTM provides a nonsurgical.