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Autologous Fat Grafting’s Role in Primary Rhinoplasty

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**BACKGROUND:** Autologous fat is a safe and effective soft tissue filler. Reports of the efficacy of fat grafting to enhance rhinoplasty in the literature are scarce. This study is a retrospective study investigating the effect autologous fat grafting on edema and ecchymoses as well as Face-Q scores following rhinoplasty.

**METHODS:** Patients undergoing rhinoplasty at Yale New Haven Medical Center were reviewed. 3-D images were acquired utilizing a Vectra 3-D camera (Canfield Scientific, NJ). All measurements were performed with Mirror (Canfield Scientific, NJ). Ecchymoses were outlined utilizing a magnetic lasso followed by an area measurement. Edema was measured by subtracting the post-operative image from the pre-operative image excluding the nose and mouth from the region of interest. Edema and ecchymosis were measured at 7–10 day and 4–6 week intervals. Significance is defined as p=0.05. Patients were asked to complete the satisfaction with face, nose, and nostrils in addition to the social and psychological function modules of the Face-Q.

**RESULTS:** One hundred patients underwent primary rhinoplasty with the senior author from 2013–2017. 40 were identified which did not have fat grafting. Age, gender, surgical approach, and osteotomy distribution was similar between the groups. In the 7–10 day time interval the fat grafted group showed 1.15cc greater edema, (p=0.65) and 3.67cm² fewer ecchymoses (p=0.05). In the 4–6 week interval, the fat grafted group showed a lower amount of edema 5.5cc vs 6.27 (p=0.64) and 0.5cm² fewer ecchymoses (p=0.42). Overall patients reported a high degree of satisfaction with appearance of the nose (75.9 +/- 5.1), the nostrils (82.3 +/- 5.2), and of the face overall (75.2 +/- 5.0), and also reported a high degree of both psychological function (82.0 +/- 5.0) and social function (79.4 +/- 5.2) per the FACE-Q.

**CONCLUSION:** Autologous fat grafting is a useful adjunct procedure to rhinoplasty associated with a significantly lower amount of ecchymoses in the acute post-operative period and a lower amount of edema and ecchymoses four to six months following surgery. Additionally, fat grafting in rhinoplasty is associated with a high degree of patient satisfaction, psychological, and social outcomes.

Necklift through a Submental Incision: Does It Really Work?

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**PURPOSE:** While necklift through a submental incision has been well described, its effectiveness is still questioned by some authors. The goal of this study was to assess the success of the procedure in aging necks of varying severity. Additionally, we sought to determine the utility of this operation in patients with severe neck deformities including obtuse cervicomental angles and significant skin laxity.
METHODS: A retrospective review of patients who underwent necklift through a submental approach was performed. Pre-procedure and post-procedure photographs were de-identified and then mixed randomly. The scrambled photos were examined by independent evaluators in the profile and anterior-posterior view to grade the change in cervicomental angle based on the Knize (I-IV) scale. Evaluators were then asked to guess the patient’s age in before and after photos. The validated apparent age assessment scale was used to calculate the reduction of apparent age following surgery.

RESULTS: A total of 27 patients were evaluated. Post-procedure photographs were taken at an average of 24.7 months. 42% of patients were graded as mild necks and 58% as moderate to severe necks pre-operatively. There was an average apparent age reduction of 3.6 years and a 1.0 grade improvement in cervicomental angle between the pre-procedure and post-procedure photographs. When the data was isolated to the moderate to severe neck patients, there was an average apparent age reduction of 3.9 years and a 1.4 grade improvement in the cervicomental angle following surgery.

CONCLUSION: Necklift through a submental approach is an effective operation in improving the cervicomental angle and reducing the apparent age of patients by 3.6 years on average. In more severe cases, there is a 1.4 grade cervicomental angle improvement and a 3.9 year age reduction. The success of this procedure is predicated more on degree of skin laxity rather than on severity of cervicomental angle. This operation is a viable option for patients who desire neck improvement but do not want to undergo a lower facelift operation. However, patients must be counseled that the improvement is most significant in the neck profile and is limited to below the jawline.

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Waist Reducing Abdominoplasty. Do We Save Lives?

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PURPOSE: Waist circumference has been positively associated with increased mortality rate in a large number of studies. Moreover, large waist is linked to poor health even among people with normal BMI and is possibly related to specific cancers (e.g. postmenopausal breast cancer). We present our waist reducing abdominoplasty technique.

MATERIAL AND METHODS: From May 2010 to March 2017 we performed 208 abdominoplasties. We incorporated four waist reducing maneuvers in our abdominoplasty technique as following:

- One incision aggressive liposuction technique to the flanks using ultrasound assisted liposuction. The marking is different than the traditional one. We mark 4 different triangles based in anatomical landmarks. We perform different level liposuction to the upper triangles than to the lower ones and as the marking resembles the wings of a butterfly we named it after it as the Butterfly technique.
- Strong plication of the rectus sheath.
- Inferior and medial advancement of the abdominal flaps during closure.
- High Tension Stitches to central and lateral abdominal flap.
- Waist circumference has been measured at the midpoint between the lower margin of least palpable rib and the top of the iliac crest. The measurement has been taken with the patient standing, naked and at the end of normal exhale.

We measured the waist circumference before the operation and 6 months after the procedure. Patients were categorized in 3 groups regarding the BMI: Group I BMI from 18.5–24.9, Group II BMI 25–29.9 and Group III with BMI