3. The available zoom and focus improves the ability to isolate and repair the levator veli palatini muscle.
4. Modifying the Z-plasty flaps, specifically narrowing the musculomucosal flap and widening the mucosal-only flap, allows for decreased tension along the repair while maintaining adequate vascular supply to the flaps.
5. The use of an Alloderm spacer anterior to the muscular repair allows for decreased contracture to the hard palate and for an unimpeded contraction of the muscle.
6. Photos and videos are used to illustrate these technical pearls.

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Cortical Craniectomy - Effective in the Treatment of the Exposed Skull

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Exposed cranial bone can present a considerable challenge to the reconstructive surgeon. Removal of the outer cortex of exposed skull bone has proven effective in complex situations where traditional reconstruction efforts were not considered ideal.

METHODS: Three patients with exposed skull after treatment for invasive skin cancers were treated with removal of the cortical bone in the areas of exposure. All three patients had desiccated exposed bone at the sites and thin, atrophic skin surrounding the defects that negated local skin flap reconstruction. The patients were elderly, aged 72 to 92, had numerous medical problems and were not judged to be fair candidates for more complex reconstructions. The two smaller defects measured 3 x 4 cm and 4 x 4 cm and were at sites of basal cell carcinoma treatment in men with atrophic scalps scarred from previous surgeries. The largest defect was in a 92 year woman and measured 8 by 12 cm. The defect had been present for more than three years after radiation to the scalp for recurrent squamous cell carcinoma. Intermittent osteomyelitis of the skull necessitated periodic antibiotics. She wore a hair piece over the defect and a malodorous exudate was a constant companion. Reconstruction had been denied by numerous surgeons.

RESULTS: The exposed medullary bone healed in all three patients with this conservative approach. The surgery was performed as an outpatient in all three patients. Conscious sedation was utilized in two patients and one patient required only local anesthesia. The cortex removal with the drill burr was completed in less than one hour, was painless and minimal bleeding was encountered. Granulation tissue developed over the medullary bone within a four week period. Epithelialization was complete in the two smaller defects by the seventh week. The largest (8 x 12 cm) defect was judged to be healed after four months. However, a few small areas within the defect had not fully epithelialized. Clinically, the woman improved rapidly after removal of the infectious process. No osteomyelitis or infectious complications occurred after the cortical craniectomy in these patients.

DISCUSSION: Exposed skull bone is prone to desiccation and subsequent osteomyelitis if left uncovered. Complex reconstructions may not be appropriate in many situations. Atrophic scalp skin, radiation injury after skin cancer treatment and scarring from multiple surgeries often limit reconstructive options. Cortical craniectomy of the exposed skull bone is a simple, local technique that allows for secondary healing of the skull. While skin grafting to defects will shorten healing time once granulation tissue covers the medullary bone, skin grafting was not utilized in these three patients.

Monobloc and Interrupted Sutures to Plicate the SMAS

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Approaching the SMAS during a facelift has become very common, and different techniques have been described,
some more demanding, like deep SMAS treatment, and some more easy achievable, like plication.

Each of these options have their advantages and disadvantages, but it is becoming more frequent to see surgeons opting for the plication in a superficial SMAS dissection. The goal of different techniques, in these cases, is anchoring the movable SMAS to a fixed structure, using running or interrupted sutures.

Our approach is, in our opinion, a fast and safe way to suspend the SMAS, and using two practical tactics, we believe we have achieved a better long term result.

It is our option to do:

1- a monobloc suspension of the SMAS, anchoring it to the temporal fascia, a technique known as the Roundblock SMAS Treatment, with a polyamide 2-0 single suture; and

2- multiple interrupted polyamide 4-0 suture fixating the now redundant movable SMAS to the fixed parotid fascia.

We think this double suturing sustains the results for a longer period of time, compared to the previous described Roundblock SMAS Treatment, and the monobloc suspension takes away the tension sometimes found when just bringing together the SMAS and the parotid fascia.

We made the decision to use the interrupted suture in addition to the monobloc suspension as our standard technique two years ago and, since then, have less patient complaints, specially concerning residual or recurrent jowls and cervical laxity.

As other advantages associated with the use of both tactics, we have a smaller dissection and scars, less facial nerve transitory lesions, flap necrosis, and haematomas, compared to extended skin and/or SMAS dissection.