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Achieving Predictable and Stable Results in Primary and Secondary Augmentation Mastopexy

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The approach to the ptotic breast requiring an augmentation as well as the mastopexy has been the subject of much discussion and divergent thought over the past few decades. Whereas in the past the trend has been to preferentially stage these procedures due to the concerns over safety and/or efficacy of performing these procedures at one time, recently there has been a growing understanding and interest in approaching these patients with a simultaneous augmentation mastopexy.

In this presentation, a sequential and logical approach to achieving predictable results with the simultaneous approach will be discussed. The pertinent publications will be reviewed to help understand the challenges encountered with these procedures. The use of many different types of implants (smooth, textured, round, shaped) will be emphasized, as well as decisions on the type of mastopexy and the pocket location. Additionally, the special considerations and approach to the revisional augmentation mastopexy will be reviewed with review of multiple cases for illustration. The approach to managing a ptotic patient with a mastopexy alone will be discussed, with emphasis on a safe and effective approach that can be enhanced with the use of fat grafting and/or autoaugmentation.

Reconstruction of the Overresected Nose

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Secondary rhinoplasty presents a unique challenge, testing the surgeon's artistry, judgments, and ingenuity. Deformities arising from a primary rhinoplasty can range in severity from mild asymmetry on the dorsum or nasal tip to severe distortion and collapse of the osteocartilaginous structures. The most complex secondary rhinoplasty cases are those whose structural elements of the nose were overresected. Aggressive resection and weakening of the nasal skeleton, including the major support

structures of the nose, can lead to aesthetic deformities and functional problems. In secondary rhinoplasty, reconstruction of the nasal framework to produce an aesthetic and functional improvement should be the goal. Following structural rhinoplasty principles, functional deformities are treated to give the nose a more normal and balanced shape, reestablish nasal support, restore tip projection, and treat airway problems.

External approach allows full exposure of the nasal structures, deficiencies are accurately determined, and necessary changes are executed under direct vision. Autologous cartilage grafts are the preferred material to replace missing structures in secondary rhinoplasty. When we need significant support to the nose, autologous rib cartilage is the graft of choice. Rib offers an unlimited amount of cartilage for structural grafting. Long and straight struts can be prepared from rib cartilage for reinforcement or reconstruction of the septum and the alar complex.

There are 3 cardinal steps of reconstruction of an overresected nose: (1) septum reconstruction, (2) nasal tip reconstruction, and (3) dorsum augmentation and dorsum refinement.

For a predictable outcome of a secondary rhinoplasty, reconstruction of a stable septal L-strut is the first mandatory step. If the septum was left intact during the primary operation, a septal cartilage graft can be harvested from the posterior portion and used to reconstruct the septal L-strut. However, in the majority of overresected noses, the septal cartilage is not sufficient for reconstruction. If septum cartilage is not available, the best material for septal reconstruction is the rib cartilage. Straight and strong struts can be easily harvested from the rib cartilage.

In a case with overresected or deviated septum, 2 dorsal struts (spreader grafts) and 1 caudal strut have to be used for reconstruction of "septal L-strut." If tip projection and position needs to be changed, the caudal septal strut can be extended inferiorly as a "caudal septal extension graft."

The goal of the secondary tip surgery is anatomic reconstruction of the nasal tip framework and reconstruction of a stable nasal tip tripod to produce an aesthetic and functional improvement. In secondary cases with overresected nasal skeleton, tip projection is usually lost, which has to be reestablished. Structural grafts for tip projection include the columellar strut, the caudal septal extension graft, and tip grafts.

Weak, misshapen, malpositioned, or segmentally deficient lateral crura must be reconstructed to achieve a stable nasal tip tripod for an aesthetically pleasing outcome and the efficiency of the external and internal nasal valves. The lateral crural graft is a versatile tool for reshaping, repositioning, or replacing the missing segments of the lateral crura.

Dorsum augmentation is one of the most delicate parts of the reconstructive rhinoplasty. A dorsal graft must be meticulously designed. The thickness, length, and width of the dorsal graft must be planned to fit the defect accurately. Despite a careful preparation, dorsal grafts have the risk of postoperative problems such as visibility, irregularities, warping, and resorption.

Diced cartilage–fascia grafts became popular in the last decade for dorsum augmentation due to advantages as easy preparation, less risk of warping, absolute unification to recipient bed, and so on. In this method, cartilage grafts are diced into small bits less than 0.5 mm² and wrapped with a fascia graft to prepare a dorsal graft. Daniel used deep temporal fascia to wrap diced cartilages.

When the positive influence of an autogenous carrier such as the deep temporal fascia on cartilage viability was subsequently demonstrated, we thought that the rectus abdominis muscle fascia which is similar to deep temporal fascia can be used for this purpose. In patients whom rib cartilage was used, we harvested the rectus abdominis fascia through the same incision for diced cartilage–fascia grafting. The experience over 300 cases showed us that comparable results without resorption of diced cartilage were obtained with use of rectus abdominis fascia as a carrier.

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Lateral Skin-Platysma Displacement “LSD”: A Technique to Treat Platysma Bands and Skin Laxity Without Opening the Neck

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In spite of the different techniques used in neck rejuvenation, there are still some problems which are not completely solved even by the most aggressive techniques.

Anterior platysma bands and anterior skin laxity are among the most common complains of the patients seeking facial rejuvenation (especially over 50 years old) and represent a strong challenge to deal with.

We have been using for more than 27 years (1983-2010) a 2-layer plane technique with full neck undermining and complete platysma transection with anchoring the SMAS-platysma flap to the auriculoparotid fascia, which has given us excellent results in the early postoperative period.

A review of 150 patients submitted by us to neck rejuvenation through this technique, however, showed some flaws of this technique.

Despite the aggressive manoeuvres involved in this approach, some patients still show, as early as 6 months from the surgery, recurrence of the muscular cords over the anterior neck, which are either incompletely removed or, more probably, newly formed bands which may constitute a frustration for both patient and surgeon.

Various hypotheses on the causes and the dynamics of the recurrence of the bands are examined.

A further flaw of this technique is represented by the excess of anterior cervical skin which in many patients cannot be eradicated even through a complete neck undermining and traction on the superficial and deep flaps.

Another downside of all techniques which involve full neck undermining is constituted by the increased complication rate and by the long recovery period needed for the patient to go back to his normal social life.

Due to the frequent recurrence of platysma bands and anterior skin laxity that we noticed in the medium term and the complains we received from the patients for the long recovery period related to this approach, we developed a new technique, “The LSD” (lateral skin-platysma displacement), which is based on different principles from the ones we have carried out in the past.

It entails only a lateral approach with mere periauricular incision, a site of attack to the platysma in an area much closer to the bands and a relocation of the anterior platysma in a more lateral position which, in other words, means removing the muscle from the anterior neck.

Furthermore, this approach allows an easier reduction of the submandibular glands if compared to the submental approach, as it allows a wider exposure of the surgical field and a less time-consuming procedure

The advantages of this technique are multiple:

- Limited undermining
- No opening the anterior neck
- Almost no risk of nervous injuries
- Easy reduction of SMG
- Optimal results on platysma bands
- Optimal results on treating anterior skin excess

It is a technique which we have been using in the last 5 years which showed to be less risky, less time consuming, and successful in treating both platysma bands and anterior skin laxity.

My Approach to Cosmetic Blepharoplasty: Upper Eyelid Volume Preservation and Selective Orbicularis and Crease Modification With Lower Eyelid: Orbicularis Muscle and Lateral Retinacular/Canthal Suspension

Steven Fagien, MD, FACS

Traditional blepharoplasty had more commonly been a procedure of soft tissue reduction by excision of skin, muscle, and fat. More recent approaches to comprehensive blepharoplasty utilize soft tissue preservation and selective lower eyelid suspension in the appropriate patient. In this presentation, I will discuss appropriate patient selection and titration of various approaches to achieve better results and greater patient satisfaction.

Body Contouring in the Massive Weight Loss Patient—Tips, Pearls, and Evolving Techniques

Jonathan Toy, MD, FRCS(C)

University of Alberta

Obesity is an increasing health issue for millions of people around the world. With bariatric surgery becoming commonplace, demand for plastic surgery after massive weight loss (MWL) is skyrocketing. Body contouring in the MWL patient

requires modification of existing techniques and the utilization of new techniques specifically designed to deal with extreme amounts of excess skin and soft tissue deflation and descent. With multiple body areas needing treatment, the staging and combinations of procedure can be a complex process. Safety and risk management in the patient is of paramount importance.

Learning Objectives

At the end of this session, the learner will be able to:

1. Recognize the expanding issue of the MWL patient in view of body contouring and the role of the plastic surgeon
2. Assess, create a surgical plan, and stage surgical procedures for the patient presenting for body contouring after MWL
3. Identify safety issues and minimize risk in body contouring patients after MWL

The Evolution of an Operation

David Whiteman, MD, FRCS(c)

I will try to demonstrate the evolving changes in abdominoplasty. As is standard procedure in cosmetic surgery, this basic operation can be selectively modified for individual patient needs. In some ways, I believe it mimics the evolution of facelift strategies to treat the variations in patient presentation.