Abstracts / Resumos

De Cordier BC, de la Torre JI, Al-Hakeem MS, Rosenberg LZ, Gardner PM, Costa-Ferreira A, Fix RJ, Vasconez LO.

Endoscopic forehead lift: review of technique, cases, and complications.

Plast Reconstr Surg. 2002;110(6):1558-68; discussion 1569-70.

Endoscopy has provided a significant improvement in the surgical rejuvenation of the upper face. It offers a minimally invasive alternative that avoids many of the undesirable effects associated with the coronal approach. The standard minimal access forehead endoscopic procedure consists of a subperiosteal undermining through three small triangular prehairline incisions. To successfully elevate the eyebrows, it is essential to release the periosteum at the level of the supraorbital rims and ablate the brow depressor muscles of the glabella. Until the periosteum reattaches itself, elevation is maintained by a temporary suspension suture between staples at the incision sites and 5 cm posterior to the hairline. The transverse closure of the triangular skin incisions achieves some additional elevation. The biplanar approach adds a partial subcutaneous undermining of the forehead to the endoscopic technique and allows plication of the frontalis muscle and excision of excess forehead skin. It is offered to patients with very ptotic eyebrows, deep transverse wrinkles, or a high forehead. The prehairline incision is a disadvantage but is tolerated quite well in older patients. The medical records of 393 consecutive patients who underwent endoscopic forehead lift from 1994 to 2000 were reviewed. Because seven patients had the endoscopic forehead lift repeated, the number of forehead endoscopies totaled 400. The complication rate was quite acceptable and did not markedly increase when a forehead lift was performed in combination with other facial procedures. The endoscopic forehead lift consistently attenuated the transverse forehead wrinkles, reduced the glabellar frown lines, and raised the eyebrows. It provided an appearance that was less tired and angry in addition to opening the area around the eyes. Long-term follow-up has shown that the endoscopic forehead lift produces lasting and predictable results

Neto MS, Castilho HT, Ferreira LM, Hochberg J, Toledo SR.

Utilization of the depressor anguli oris musculocutaneous flap for lip reconstruction.

Ann Plast Surg. 2000;44(1):23-8.

The authors describe the anatomic aspects and surgical technique of the depressor anguli oris musculocutaneous flap for reconstruction of the upper and lower lips. Twenty patients were submitted to surgical treatment, 19 for carcinoma and for upper lip scar deformity. In all patients the repair was performed with the depressor anguli oris musculocutaneous island flap. At the follow-up, lip function was satisfactory in 19 patients and unsatisfactory in 1 patient. The aesthetic results were considered satisfactory in all patients. The depressor anguli oris musculocutaneous island flap is safe for upper and lower lip reconstruction, with good functional and aesthetic results, and can be added as a new flap for lip reconstruction.

Fryzek JP, Signorello LB, Hakelius L, Feltelius N, Ringberg A, Blot WJ, McLaughlin JK, Nyren O.

Self-reported symptoms among women after cosmetic breast implant and breast reduction surgery.

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A retrospective cohort study was performed in Sweden to evaluate the possibility that an individual symptom or constellation of illness symptoms related to silicone occurs in women after breast implant surgery. A random sample (n = 2500) of all women in the Swedish national implant registry who underwent breast augmentation surgery with alloplastic breast implants during the years 1965 through 1993 was compared with a sample (n = 3500) of women who underwent breast reduction surgery during the same period, frequency matched to the implant patients for age and calendar year at the time of surgery. In total, 65 percent of the breast implant patients (n = 1546) and 72 percent of the breast reduction patients (n = 2496) completed a self-administered questionnaire covering 28 rheumatologic and other symptoms and lifestyle and demographic factors. Practically all of the 28 symptoms inquired about were reported more often by women in the breast implant cohort, with 16 (57 percent) significantly more common in breast implant recipients. In contrast, few significant differences or consistent patterns were observed in the length of time since the implant and in the type (silicone or saline) or volume of the implant. Although women with breast implants report a multitude of symptoms more often than women who have breast reduction surgery, the lack of specificity and absence of dose-response relationships suggest that the excess of reported symptoms is not causally related to cosmetic implants.