



TECHNIQUES IN

AESTHETIC CRANIOFACIAL SURGERY

KENNETH E. SALYER

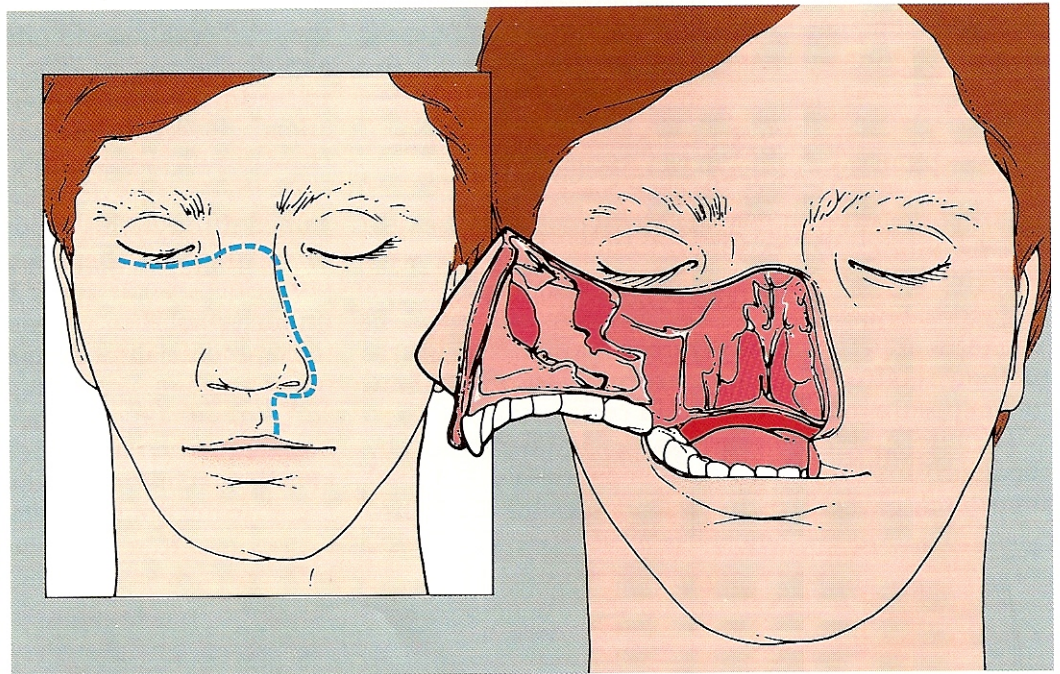
FOREWORDS BY DANIEL MARCHAC AND FERNANDO ORTIZ MONASTERIO

FACIAL APPROACH

Access to the retromaxillary area, as described by Hernandez-Altemir, can be obtained with modifications as needed. In the unilateral facial approach, external skin incisions are necessary around the nose on the contralateral side, over the dorsum, and below the eyelid, hinging open the maxilla on its soft tissue attachment. The vertical incision of the vestibular mucosa must not coincide with the palatine alveolus osteotomy.

The osteotomies may vary, but most commonly extend through the zygoma, along the edge of the orbital rim, above the medial canthus and through the nasal bone, down through the hinged alveolus between the lateral and central incisor on the side of the initial incision. The incision through the palate begins directly behind the lateral incisor on that side and goes through the pterygomaxillary junction. This allows the entire maxilla to be hinged out on a subcutaneous pedicle (Fig. 1.10).

Fig. 1.10 This approach to the retromaxillary region, which was described by Hernandez-Altemir, gives good intrafacial access for tumor resection. The maxilla is hinged open on a pedicle of the facial soft tissues after osteotomies are made as needed, and the palate is incised through to the pterygomaxillary junction.



Such wide exposure of the retromaxillary area offers the opportunity to reach such structures as the base of the cranium, orbit, pterygomaxillary area, nasal area, cavum, clavius, sphenoid sinus, and temporal zygomatic region. This is particularly advantageous in tumor resection as well as in reconstruction of traumatic and certain congenital deformities.

SPLIT LAMELLAR TECHNIQUE

This osteotomy introduces a new technique in which the facial skeleton is split between the internal and external bony lamella. This osteotomy allows a quantifiable translocation of the external table against the native position of the internal table (Fig. 1.11). This interlamellar osteotomy has led to improved aesthetic results in the orthomorphic reconstruction of congenital deformities.

The split orbitofacial osteotomy was developed by us from performing over 400 orbitofacial osteotomies and from technical improvements in surgical equip-

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