

Dorsal Augmentation Using Autogenous Tissues

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KEYWORDS

- Asian rhinoplasty • Dorsal augmentation • Diced cartilage • Dermofat graft • Temporal fascia
- Costal cartilage graft • Folded dermal graft

KEY POINTS

- Autogenous tissues used for major dorsal augmentation in Asian noses are dermofat, solid block costal cartilage, and diced cartilage.
- Vertically oriented folded dermal graft technique provides high profile graft, minimizes resorption, and is a good technique for major dorsal augmentation.
- A solid block costal cartilage graft permits the largest amount of dorsal augmentation among autogenous tissues, and provides more defined dorsum.
- The diced cartilage graft shows less resorption than dermofat graft, and can be easily performed by novice surgeons.

Unlike Western nations, the material most commonly used for dorsal augmentation in Asian countries still is an implant. The reason is that an implant not only provides a further defined and more beautiful dorsal shape, but also requires shorter operating time without the donor site morbidity associated with autogenous tissue harvesting. Nonetheless, nasal dorsal augmentation using autogenous tissue still is the ultimate goal for aesthetic rhinoplastic surgeons, because autogenous tissue is less likely to cause implant-related complications such as infection, dorsal skin thinning and redness, capsular contracture, and implant exposure through the tip skin or vestibular mucosa. Autogenous tissues used for major dorsal augmentation of Asians are largely dermofat, solid block type costal cartilage, and diced cartilage.

DORSAL AUGMENTATION WITH DERMOFAT

Dermofat graft is the most commonly used autogenous tissue for dorsal augmentation in East Asian countries.¹ In particular, dermofat graft can be

most safely performed to the thinned dorsal skin after the removal of illegally injected foreign liquid material to the dorsum, which was rather common in some Asian countries.²

Operative Technique

Harvest procedures

In the sacrococcygeal area, the dermis is thicker than anywhere else in the body. In addition, the subdermal fat layer is relatively dense. These anatomic properties of the sacrococcygeal soft tissue create for an excellent source of dermofat graft.³ This is also one of the most covered areas of the body, and postoperative scars are inconspicuous. A graft is harvested from 1 side of the buttock close to the intergluteal crease. The medial margin of the graft is located about 2 to 3 mm lateral to the crease (**Fig. 1**). The dermofat will undergo contracture immediately upon harvest. Thus, the design of dermofat should incorporate larger-than-needed dimensions to account for the contracture. For the purpose of dorsal augmentation, the author

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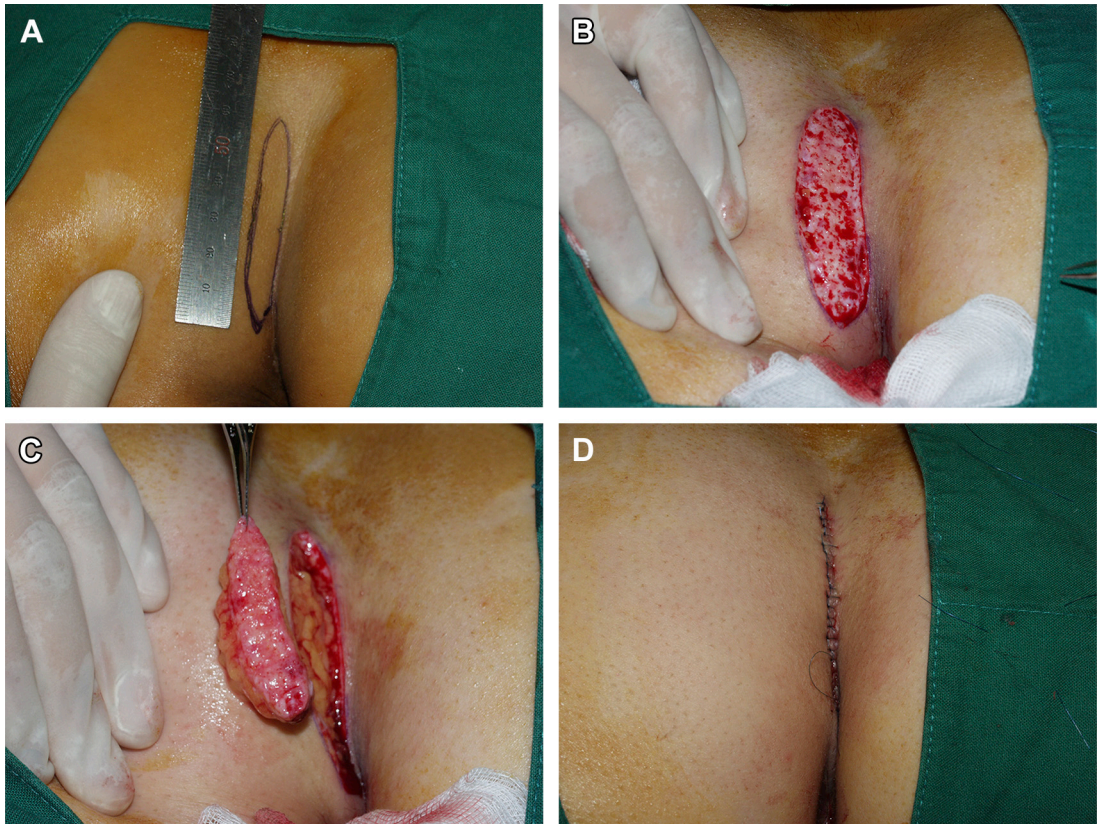


Fig. 1. Harvesting the dermofat graft. (A) Graft is harvested from one side of the buttock close to the intergluteal crease. (B) After the skin incision along the designed line, deepithelization is performed. (C) The dermis and fat layer are harvested. (D) Wound closure.

harvests dermofat that is 60 mm long, 10 to 12 mm wide, and 6 to 10 mm deep. The author designs the lowermost point of the incision at least 3 cm above the anus.

The skin is incised using a No. 15 blade without exposing the subcutaneous fat. The dermis is deepithelized by peeling off the epidermis using a No. 10 blade. Incomplete removal of epidermis should be avoided because it can result in epidermal cyst at the graft site. Upon complete deepithelization, the dermal incision is carried down into the subcutaneous tissue. Once the incision is at an adequate depth, the whole graft is elevated en bloc.

Dorsal augmentation technique

Unlike silicone implants, dermofat grafts are placed in the supraperichondrial and supraperiosteal planes.

The superior end of a silicone implant is usually placed at the height of upper eyelash line or the supratarsal fold. The dermofat graft should be placed a bit more cephalically than this upper point. For most patients, the author finds the

midpoint between the supratarsal crease and the eyebrow to be appropriate (**Fig. 2**). This placement will tend to result in a natural augmentation of the radix upon partial resorption of the dermofat. Inferiorly, the caudal endpoint of dermofat should reach to the nasal tip.



Fig. 2. The starting point of the dermofat graft is approximately the midpoint between the double eyelid crease and eyebrow.

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