

Sideburn Reconstruction

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ABSTRACT

The lifting of hair temple implantation line elongates the distance between the mandibular angle area and the sideburn. Caused in general by immoderate face lifting, it gives the operated individual an unpleasant and stereotyped aspect.

When describing the “Copacabana Syndrome”, we are translating our despair in face of the risk of having facial plastic lose its prestige. This threat comes from some surgeons that have not understood the modern philosophy of face rejuvenescence plastic yet.

The solution for the problem was found as a random, neighboring lap transposed from retroauricular area to the area where sideburn is anatomically localized.

INTRODUCTION

Several surgeons^(2, 5, 6, 9) have highlighted the importance of maintaining the hair implantation line.

The excessive lifting or absence of sideburns because they were excised or suffered alopecia due to excessive traction of temporal lap is a very unpleasant sequela^(2, 7, 10). This is generally due to immoderate facial plastic that causes an increase of face longitudinal size, giving the patient a “plastic operated” stereotyped aspect.

This is the “Copacabana Syndrome”: millions of unlucky ladies, with pulled back faces and resembling one another, whose appearance shock us when they walk around the neighboring.

The solution for the problem, in a secondary lifting or even with an isolated treatment of the deformity, was the employment of a random, neighboring, dermal-adipose and transposing scalp lap, from retroauricular region to the zone of the new sideburn.

METHOD

Twelve laps were carried out in six patients (54 to 73 years old) previously submitted to one or more ritidoplasties. The face lifting evolution time ranged from two to eight years. All of them presented complaints of different intensive-degree of temple alopecia

(Figs. 1 and 3).

The neighboring scalp lap was thought as the solution for the problem. This is a parietal-occipital, random, dermal-adipose lap juxtaposed posterior to the temporal scar, frequently present in rithidoplasties⁽⁹⁾. Lap is a transposing one and migrates to the defective glabrous area recomposing sideburn (Figs. 5, 6 and 7).

Surgical Technique: The lap measures approximately 9 x 3.5 cm (Fig. 5). In general, interventions are carried out under local anesthesia and concurrently to secondary lifting. The lap area shall not be infiltrated with solution containing vasoconstrictors. Incisions are beveled in order to respect inclination of pileous bulb. The technique must be absolutely traumatic and the lap shall not be touched with tweezers but rather with Gilles clamps.

The dissection plane is juxta-supra-gallic. Transposition shall be performed with absolutely no tension. The receptor area skin is sufficiently excised to comfortably accommodate the lap. Penrose's drain is put under lap for 12 hours.



Fig. 1 - Preoperative. Right profile of a 60-year old patient, presenting alopecia zone at sideburn area by successive traction-rotations of face lifting.

Fig. 1 - Pré-operatório. Perfil direito de paciente de 60 anos, apresentando zona de alopecia na área da costeleta, por trações- rotações sucessivas de face liftings.

RESULT

Good, recovering the face longitudinal length size and with a feeling of normality in profile view. As it is natural, we have noticed patients' satisfaction in the short and long run (Figs. 2 and 4).

DISCUSSION

According to our observations, the excessive lifting or its loss is one of the most important sequelae of face lifting related to the area around the ear. Its causes are:

- ◆ Excessive lap traction, caudal-cephalic sense, in patients having sideburns already highly-implanted.
- ◆ Excessive facial lap traction-rotation, the sideburn zone being substituted by glabrous skin.
- ◆ Loss of sideburn by capillary bulb lesion due to excessive traction or shallow dissection of lap.



Fig. 2 - Late postoperative (16 months) of patient in Fig 1., with sideburn reconstructed, in right profile, treated according to the technique described by the authors.

Fig. 2 - Pós-operatório tardio (16 meses) da paciente da Fig. 1, com a costeleta reconstruída, perfil direito, tratada pela técnica descrita pelos autores.



Fig. 3 - Preoperative of a 58-year old patient, in right profile, presenting total loss of sideburn substituted by glabrous skin, after immoderate face lifting.

Fig. 3 - Pré-operatório de paciente de 58 anos, em perfil direito, apresentando perda total da costeleta, substituída por pele glabra, pós face lifting imoderado.



Fig. 4 - Immediate postoperative of patient in Fig. 3 (eight days) in right profile, after having been operated according to the technique for sideburn reconstruction described by the authors.

Fig. 4 - Pós-operatório imediato da paciente da Fig. 3 (oito dias), em perfil direito, após ter sido operada pela técnica descrita pelos autores para a reconstrução das costeletas.



Fig. 5 - Intraoperative showing temporal-occipital lap raised from its bed and being transposed towards the receptor bed to form the new sideburn.

Fig. 5 - Transoperatório, mostrando o retalho temporo-occipital levantado de seu leito e sendo transposto em direção ao leito receptor para formar a nova costeleta.



Fig. 6 - Schematic drawing of temporal-occipital lap transposition to the zone anterior to the helix root where it will form the new sideburn. Note the closing alternative for occipital incision.

Fig. 6 - Desenho esquemático da transposição do retalho temporo-occipital para a zona anterior à raiz da hélix onde irá formar a nova costeleta. Repare a alternativa da incisão occipital para o fechamento.



Fig. 7 - Schematic drawing showing lap already migrated to the proposed zone and aspects of donor zone already closed.

Fig. 7 - Desenho esquemático mostrando o retalho já migrado à zona proposta e aspectos da zona doadora já fechada.

The patient almost always is discontent with the result and, even knowing where the problem is, she considers this as a normal result in facial plastic, and thinks there is no other solution.

Our proposal is relatively simple if compared to other ones^(1, 2, 5). The entire technique is carried out at one unique time, which grants a consistent and highly psychological important result at immediate postoperative period once the flap brings with it a dense pileous area to the affected region. Dardour⁽⁴⁾ refers to a small similar design flap, without, however, giving details on it and the operation technique to be employed.

Closing of donor area is made by simple approaching to scalp being not possible to have any tension whatsoever. Detachment is ample and, when required, a relaxing incision with occipital zone sliding is made (Figs. 6 and 7).

We have not had any complication till now even having operated elderly patients and smokers.

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