PREOPERATIVE DIAGNOSIS:, Left nasolabial fold scar deformity with effacement of alar crease.,POSTOPERATIVE DIAGNOSIS:, Left nasolabial fold scar deformity with effacement of alar crease.,PROCEDURES PERFORMED:,1. Left midface elevation with nasolabial fold elevation.,2. Left nasolabial fold z-plasty and right symmetrization midface elevation.,ANESTHESIA: , General endotracheal intubation.,ESTIMATED BLOOD LOSS: , Less than 25 mL.,FLUIDS: , Crystalloid,CULTURES TAKEN: , None.,PATIENT'S CONDITION: , Stable.,IMPLANTS: , Coapt Endotine Midface B 4.5 bioabsorbable implants, reference #CFD0200197, lot #01447 used on the right and used on the left side.,IDENTIFICATION: , This patient is well known to the Stanford Plastic Surgery Service. The patient is status post resection of the dorsal nasal sidewall skin cancer with nasolabial flap reconstruction with subsequent deformity. In particular, the patient has had effacement of his alar crease with deepening of his nasolabial fold and notable asymmetry. The patient was seen in consultation and felt to be a surgical candidate for improvement. Risks and benefits of the operation were described to the patient in detail including, but not limited to bleeding, infection, scarring, possible damage to surrounding structures including neurovascular structures, need for revision of surgery, continued asymmetry, and anesthetic complication. The patient understood these risks and benefits and consented to the operation.,PROCEDURE IN DETAIL: , The patient was taken to OR and placed supine on the operating table. Dose of antibiotics was given to the

patient. Compression devices were placed on the lower extremities to prevent the knee embolic events. The patient was turned to 180 degrees. The ETT tube was secured and the area was then prepped and draped in usual sterile fashion. A head wrap was then placed on the position and we then began our local. Of note, the patient had previous incisions just lateral to his lateral canthus bilaterally and that were used for access. Local consisting a 50:50 mix of 0.25% Marcaine with epinephrine and 1% lidocaine with epinephrine was then injected into the subperiosteal plane taking care to prevent injury to the infraorbital nerves. This was done bilaterally. We then marked the nasolabial fold and began with the elevation of the left midface.,We began with a lateral canthal-type incision extending out over his previous incision down to subcutaneous tissue. We continued down to the lateral orbital rim until we identified periosteum. We then pulled in a periosteal elevator and elevated the midface down over the zygoma elevating some lateral mesenteric attachments down over the buccal region until we felt we had reached pass the nasolabial folds medially. Care was taken to preserve the infraorbital nerve and that was visualized after elevation. We then released the periosteum distally and retracted up on the periosteum and noted improved contour of the nasolabial fold with increased bulk over the midface region over the zygoma.,We then used our Endotine Coapt device to engage the periosteum at the desired location and then elevated the midface and secured into position using the Coapt bioabsorbable screw. After this was then carried out,

we then clipped and cut as well as the end of the screw. Satisfied with this, we then elevated the periosteum and secured it to reinforce our midface elevation to the lateral orbital rim and this was done using 3-0 Monocryl. Several sutures were then used to anchor the orbicularis and deeper tissue to create additional symmetry. Excess skin along the incision was then removed as well the skin from just lateral to the canthus. Care was taken to leave the orbicularis muscle down. We then continued closing our incision using absorbable plain gut 5-0 sutures for the subciliary-type incision and then continuing with interrupted 6-0 Prolenes lateral to the canthus.,We then turned our attention to performing the z-plasty portion of the case. A z-plasty was designed along the previous scar where it was padding to the notable scar deformity and effacement of crease and the z-plasty was then designed to lengthen along the scar to improve the contour. This was carried out using a 15 blade down to subcutaneous tissue. The flaps were debulked slightly to reduce the amount of fullness and then transposed and sutured into place using chromic suture. At this point, we then noted that he had improvement of the nasal fold but continued asymmetry with regards to improved bulk on the left side and less bulk on the right and it was felt that a symmetrization procedure was required to make more symmetry with the midface bilaterally and nasolabial folds bilaterally. As such, we then carried out the dissection after injecting local as noted and we used a 15 blade scalpel to create our incision along the lateral canthus along its

preexisting incision. We carried this down to the lateral orbital rim again elevating the periosteum taking care to preserve infraorbital nerve.,At this point, we then released the periosteum distally just at the level of the nasolabial fold and placed our Endotine midface implant into the desired area and then elevated slightly just for symmetry only. This was then secured in place using the bioabsorbable screw and then resected a very marginal amount of tissue just for removal of the dog ear deformity and closed the deeper layers of tissue using 3-0 PDS and then closing the extension to the subciliary area using 5-0 plain gut and then 6-0 Prolene lateral to the canthus.,At this point, we felt that we had achieved improved contour, improved symmetry, and decreased effacement of the nasolabial fold and alar crease. Satisfied with our procedures, we then placed cool compresses on to the eyes.,The patient was then extubated and brought to the PACU in stable condition.,Dr. X was present and scrubbed for the entire case and actively participated during all key elements. Dr. Y was available and participated in the portions of the case as well.