

patients should not be based on standard non-cleft patient data.

Independently of this, we have checked the Scheuer et al. (1993) study and are in a position to confirm their results.

The article we cited is five pages before the publication of Gundlach et al. (1993). Our discrepancy can surely be cleared up.

References

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Dr. Dr. E. Keese

Mund-, Kiefer-, Gesichtschirurgie
(Nordwestdeutsche Kieferklinik)
Martinistr. 52
20246 Hamburg
Germany

The sandwich zygomatic osteotomy

M. Y. Mommaerts, J. V. S. Abeloos, C. A. S. De Clercq, L. F. Neyt
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Sir

The article deals with a series of 20 patients with developmental facial deformities, which were treated by bilateral sandwich zygomatic osteotomy. The authors described in detail the technique used in combination with well illustrated pictures. In the literature list, I miss the article of Eduardo J. Gimenez (Osteotomia del hueso malar) who published the technique in 1973, where similar combined oblique and vertical osteotomy lines are described and illustrated. The current authors of this article used an interpositional porous hydroxyapatite block to maintain the laterally displaced greenstick fracture that occurs at the temporo-zygomatic suture. In the article described by Eduardo J. Gimenez, the resultant greenstick fracture at the temporo-zygomatic suture is stabilized by a F. Urban splint. We indeed agree, replacing the F. Urban splint by an interpositional graft. The experience teaches that the use of autologous bicortical bone harvested from the chin gives satisfactory results, even if a genioplasty is not necessarily indicated.

S. Walji

Academic Hospital Nijmegen St. Radboud
Dept. of Oral and Maxillofacial Surgery
6500 HB- Nijmegen
The Netherlands

Reply

In his letter, Dr Walji has raised two issues: firstly, the origin of the technique and secondly, the stabilisation of the valgus position.

Our article concentrated on a technique for bilateral malar augmentation in cases of developmental hypoplasia. Of course, numerous osteotomies are described to reposition a traumatically displaced zygoma. Dr Walji points at such an osteotomy type, described in a 1973 issue of the *Revista Assoc. Odont. Argent.* by Dr E. Gimenez. It concerns a report on four cases of unilateral posttraumatic malar impaction, partially corrected by performing a vertical, infraorbital and oblique chisel osteotomy in the posterior sinus wall. The infraorbital nerve is exposed, the masseter muscle insertions are stripped off, the zygomatic arch and the malar body is dissected subperiosteally along its entire facial surface. Stabilization is performed with an acrylic block in the infraorbital osteotomy gap. I would not advise the readers to correct post-traumatic malar deformities in such a way. Aseptic necrosis of the zygoma, sinusitis induced by the foreign body, and especially persistence of the enophthalmos, canthal dystopia and infraorbital rim recession, are potential complications. Maybe for these reasons, long-term results are not discussed in Dr Eduardo J. Gimenez's article.

Respecting the editor's desire that '... authors must refrain from citing too many references in the article ...' (Editorial, *J. Cranio-Max.-Fac. Surg.* 22 (1994) 1) I try to refer to articles that are directly related to the topic discussed. The literature search is done accordingly, with the languages English, German, French, and Dutch as four more restricting parameters.

I agree that autologous bone should be the first choice material in the correction of facial skeletal deformities, whatever the cause may be, congenital, developmental or posttraumatic. Therefore, I sincerely hope that Dr Walji will be able to report less resorption rates with bone grafts when used for the malar body displacement than Drs. Vargervik, Farias and Oosterhout had for the stabilization of the zygomatic arch displacement (*J. Cranio-Max.-Fac. Surg.* 15 (1987) 208–212).

M. Mommaerts MD, DMD

Dir. of Maxillo-Facial Surgery
A.Z. St.-Jan
Ruddershove 10
B-8000 Brugge
Belgium