ORBITAL DYSTOPIA RAPOSO, BRADLEY pdf

1: Otolaryngology | Atlas of Operative Craniofacial Surgery

Nonsyndromic Craniosynostosis: Current Treatment Options Cohen, Mittermiller, Meltzer, Levy, Broder, Ozgur 7. Syndromic Craniosynostosis Buchman, Muraszko 8. Successful Separation of Craniopagus Conjoined Twins Using a Staged Approach: An Evolution in Thought Staffenberg, Goodrich 9. Orbital Dystopia Raposo, Bradley

When Tessier introduced his concepts of both an intra and extracranial approach to treat severe craniofacial malformations, like hypertelorbitism, the modern field of craniofacial surgery was ushered in. The aims of this study were the following: To compare preoperative and postoperative interorbital distance in patients with hypertelorbitism who underwent hyperteleorbitism correction. To evaluate the orbital relapse rate, 6 months after hyperteleorbitism correction. Eleven patients underwent hypertelorbitism correction. The interorbital distance was measured at frontal cephalograms preoperatively, and with a caliper intraoperatively and at 6 months after surgery using the frontal cephalograms. Orbital relapse was measured by subtracting the follow-up measurement from the intraoperative measurement. Wilcoxon test was used to compare preoperative interorbital distance and postoperative interorbital distance. A value of p Conclusion: Hypertelorbitism correction allows the orbital mobilization trough an intracranial approach, and leads to a satisfactory aesthetic and functional outcomes. The average orbital relapse rate was 1. Os objetivos do presente trabalho foram: DIO entre 30 e 34 mm; segundo grau: DIO maior que 34 mm e menor que 40 mm; terceiro grau: DIO maior que 40 mm. Por outro lado, McCarthy et al. Cinco pacientes eram do sexo masculino e 6 pacientes do sexo feminino. O couro cabeludo foi suturado por planos. Foram introduzidos 2 drenos, que permaneceram por 2 dias Figura 1. Com base nos estudos de Whitaker et al. Embora os estudos de McCarthy et al. The treatment of facial dysmorphy peculiary to cranio-facial dysostosis C. Crouzon and Apert diseases. Total osteotomy and sagittal displacement of the facial mass. Scand J Plast Reconstr Surg. Van der Muelen JC. Br J Plast Surg. Surgery related to the correction of hypertelorism. Ocular hypertelorism and pseudohypertelorism. Advances in surgical treatment. Deformities of the midface resulting from malunited orbital and naso-orbital fractures. Facial skeletal changes following hypertelorbitism correction. Hypertelorism correction in the young child. The K stitch for hypertelorbitism: Ocular adnexal problems in craniofacial deformities. Reflections on cranio-facial surgery in children today and in the future. Treatment of facial dysmorphisms in craniofacial dysostosis DCF. Definitive treatment of orbital hypertelorism OR. Scan J Plast Reconstr Surg. Facial bipartition with monobloc distraction using roman keystone arch fixation. Proceedings of the twelfth international congress of The International Society of Craniofacial Surgery.

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2: RBCP - Orbital relapse after hypertelorbitism correction

Addressing the complete range of craniofacial anomalies, from cleft lip and orthognatic surgery to acute facial fractures and tumors, this source provides step-by-step instruction on the anesthetic management, surgical work-up, and operative treatment of complex congenital or acquired anomalies affecting the head, upper face, and jaw.

The overall mean of the surgical results classified according to the Whitaker need for surgical revision 20 was 2. All patients have had normal intellectual development and are still in follow up on our service. DISCUSSION The correction of hyperteleorbitism has been a challenge for plastic surgeons dealing with craniofrontonasal dysplasia 17 , since such patients often have severe and asymmetric hyperteleorbitism 17 , 21 , therefore requiring a great mobilization of the orbits in three dimensions Since the first description of craniofrontonasal dysplasia 8 , the surgical treatment of hyperteleorbitism in these patients has been restricted only to reports of isolated cases and to retrospective series in the international context 12 - Although there are national publications 18 , 19 , 22 , 23 that address the surgical correction of hyperteleorbitism of several craniofacial deformities together, this is the first Brazilian study that brings the peculiarities of the intracranial and extracranial interventions performed for the treatment of hyperteleorbitism in patients with craniofrontonasal dysplasia. In the literature, after Tessier 3 - 6 described the surgical principles of the intra and extracranial approach for the correction of hyperteleorbitism, many adaptations and technical innovations have been published, especially those described by Van der Muelen 24 , 25 , who modified the box osteomy and created the facial bipartition. The latter comprises the medial rotation of the two hemifaces by means of the intracranial access, associated with successive osteotomies at the pterygomaxillary junction and palatine plates, simultaneously correcting the orbits and the inverted "V" occlusion reported in patients with hyperteleorbitism. In addition, Converse et al. Although there are national reports on the treatment of hyperteleorbitism by extracranial osteotomies 22 , 23 , the procedures of choice have been the orbital box osteotomy and facial bipartition 17 - 19 , 21 , as both techniques allow the three-dimensional mobilization of the target structures and, therefore, the approach of a broad spectrum of clinical presentation of hyperteleorbitism. In the particular scope of craniofrontonasal dysplasia, Kawamoto et al. It has also been argued that facial bipartition is simpler to perform and does not require osteotomies in the interorbital region that may compromise dental buds and lacrimal pathways 15 , It is important that these aspects 15 , 17 be considered; However, significant rotation of the hemifaces during facial bipartition in adult patients with severe hyperteleorbitism produces a diastema of the central maxillary incisors which may be very difficult to correct orthodontically and potentially require a LeFort I osteotomy Moreover, in these patients, dental buds are at potential risk during the rigid fixation of the osteotomy segments in the nasomaxillary and zygomaticomaxillary pillars Based on this, we prefer the orbital box osteotomy for the correction of hyperteleorbitism in adult patients with normal maxillary morphology and acceptable occlusion, while reserving facial bipartition to treat patients with mixed or deciduous dentition With this surgical approach, we obtained a significant improvement in the craniofacial symmetry of all patients evaluated, there being need of additional surgeries of the craniofacial contour categories II and III of Whitaker The coronal suture fusion pattern unilateral versus bilateral determines the clinical characteristics of patients with craniofrontonasal dysplasia 10 , 11 , In addition to hyperteleorbitism, patients with unilateral fusion of the coronal suture also present vertical orbital dystopia, so that the orbit ipsilateral to the fusion is displaced cranially compared with the contralateral orbit 10 , 11 , Therefore, in these situations, the inverted "V" resection should be asymmetrical, the "leg" of the "V" ipsilateral to the coronal suture fusion being vertically planned, and the contralateral leg, horizontally. Total bilateral fusions of the coronal suture lead to a facial pattern with greater symmetry, although brachycephalic 10 , 11 , 17 , so that the inverted "V" resection can be symmetrical. One can apply this same reasoning to the frontal bone. Patients with unilateral coronal fusion present an asymmetric frontal region the frontal bone ipsilateral to the fusion is laterally located on the contralateral side, which usually presents with a bone hump or bulging. Thus, we perform the inversion of the bone plate in these situations, so that the bone hump is rotated degrees to be fixed in the depressed frontal region. Such a surgical

maneuver allows obtaining of facial symmetry. However, this maneuver is unnecessary in those patients with bilateral fusion of the coronal suture. Another relevant aspect in the surgical treatment of hyperteleorbitism in craniofrontonasal dysplasia is the manipulation of soft tissues The medialization of the orbits determines a tissue excess in the median region, which can be resected in the form of "Z", obeying the principles of Tessier 6 , by means of direct resection without the Z-plasty, or by using the "K" stitches 17 , The "K" stitches are named after their creator, Dr. Kawamoto, who described the technique to reduce the excess of soft tissues without the need for scars on the frontal region 17 , The technique consists in decreasing the thickness of all planes from the forehead to the dermis, but without incision in the epidermis 17 , This surgical maneuver, eventually followed by mattress suturing, leads to soft tissue contraction without the need for direct excision, as recommended by the authors 17 , Another important clinical feature is poor positioning of the medial corner, which determines a small skin fold characteristic of craniofrontonasal dysplasia and more easily identified in patients who present unilateral fusion of the coronal suture compared with those with bilateral one. The treatment of this particular deformity is fundamental, since it alleviates the stigma of craniofrontonasal dysplasia. The surgical approach can be performed by means of Z-plasty or by the technique described by Fuente del Campo 29 , which has been routinely used by the UCLA Craniofacial Clinic group The literature has reported that self-perception of a deformed face may be present in children less than four years of age Such children begin to feel different from their peers and lose the motivation to attend environments with other children As orbital repositioning improves overall facial harmony and allows the acquisition of binocular vision usually impaired due to hyperteleorbitism 18 , and early surgery has the potential to attenuate the stigmas and stereotypes faced by children with craniofacial deformities mainly in the school environment 18 , many parents seek specialized centers to resolve the anxiety related to the appearance of their children 18 , However, it is important to mention that surgical intervention for the correction of hyperteleorbitism may display recurrence of orbital position and also compromise facial growth, especially when performed in children with an immature craniofacial skeleton 19 , Two recent longitudinal studies 19 , 21 have evaluated numerous patients with hyperteleorbitism including patients with craniofrontonasal dysplasia treated surgically and have shown that age is a determining factor in the rate of orbital position recurrence. In addition, the surgical technique orbital box osteotomy versus facial bipartition was not determinant in the rate of recurrence 19 and there is a divergence regarding the effect of the severity of hyperteleorbitism on recurrence 19 , Thus, since the presence of permanent dentition may contribute to greater bone stability in the postoperative period and this is an important factor for the choice of surgical technique, we have adopted eight years as the age limit to differentiate patients who have higher or lower potential for continuous growth of the middle third of the face and patients whose state of dentition is less or more mature By applying this concept, in this study we found rates of orbital recurrence similar to the ones reported in previous studies 18 , 19 , In this context, while waiting for skeletal maturity to operate hyperteleorbitism is associated with lower relapse rates 19 , other aspects can often determine that interventions be performed in younger patients 19 , In fact, multiple factors contribute to the decision on when surgical correction should be performed 19 , Among the most relevant are the emotional and psychological responses of both parents and children with hyperteleorbitism The physical appearance of these children can be shocking, and parents are often anxious to have the surgery performed as early as possible, or before their children reach school age, to try to mitigate the challenges that children may face as they become self-critical and begin to have contact with their peers 19 , Therefore, counseling the parents of patients with hyperteleorbitism to await the maturation of the craniofacial skeleton can be a major challenge and the multidisciplinary approach for family and patients should include a discussion of all of the above issues intervention age versus outcomes versus potential risks in the short and long terms. If even with this multidisciplinary support the child and parents demonstrate the desire for surgery, it cannot be denied that, in this particular situation, the possibility of recurrence is certainly no more relevant than the desire for positive self-image and recovery of self-esteem, that allow the confrontation of prejudice derived from peers 18 , According to the presented and discussed surgical results, the approach of these patients should be individualized, respecting, whenever possible, the age and preferences of patients and their parents, as well as

the experience of surgeons. The plastic surgeon of the 20th century. The art of moving the orbits. Scand J Plast Reconstr Surg. Definite treatment of orbital hypertelorism OR. Experiences in the treatment of orbital hypertelorism. Int J Oral Maxillofac Surg. Birth Defects Orig Artic Ser. Craniofacial syndromes and surgery. Phenotypes of craniofrontonasal syndrome in patients with a pathogenic mutation in EFNB1. Eur J Hum Genet. Hypertelorism correction in the young child. Experience of surgical treatment for craniofrontonasal dysplasia. Tohoku J Exp Med. Br J Plast Surg. Rev Bras Cir Plast. Age at surgery significantly impacts the amount of orbital relapse following hypertelorbitism correction: Rev Bras Cir Craniomaxilofac. Surgery related to the correction of hypertelorism. Ocular hypertelorism and pseudohypertelorism. Advances in surgical treatment. Deformities of the midface resulting from malunited orbital and naso-orbital fractures. The K stitch for hypertelorbitism: A simple procedure for aesthetic correction of the medial epicanthal fold. Facial skeletal changes following hypertelorbitism correction. The upper face and orbit: Craniofacial biology and craniofacial surgery. March 02, ; Accepted: May 11, Mailing address: Cassio Eduardo Raposo-Amaral E-mail:

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3: DESCHAMPS-BRALY CLINIC of Plastic & Craniofacial Surgery

Orbital dystopia / Raposo, Bradley Cleft lip and palate / Cedars, Thaller Management of secondary maxillary and nasal deformities in adolescent cleft lip and palate patients / Burstein.

U nilateral coronal synostosis is characterized by premature closure of one-half of the coronal suture and consequent bilateral deformity of the cranial vault, the cranial base, and the orbitonasal region. Early surgical treatment, during the first few months of infancy, is the most effective treatment in reversing the distortion. Because the positive correcting influence of brain growth and the regenerative capacity of the cranial bone diminishes after infancy, this class of older patients requires a different surgical approach. One technique involves mobilizing and reshaping the frontal bone, orbits, and nasoethmoid complex. They may, however, obtain excellent correction from operative approaches that produce much less morbidity. In this report, three attractive and tested alternative techniques are presented for the treatment of such patients. By combining the application of acrylic with contour reshaping of the frontal bone, the surgeon may offer a safe, quick, and reliable means of creating an esthetically pleasing appearance. Operative Techniques Unilateral coronal synostosis results in ipsilateral flattening of the frontal and parietal bones and bulging prominence of the contralateral frontal and parietal bones. Vertical orbital dystopia and deviation of the nasal radix are also characteristic features. Schematic diagrams showing three methods of repairing skull asymmetry due to unilateral coronal synostosis. Acrylic augmentation is placed on the hypoplastic frontoparietal region, and the contralateral frontal bone prominence is reduced by shaving the bone. The protruding frontal bone is removed and acrylic is applied bifrontally. Frontal bone is removed bilaterally, the dura is remodeled, and subsequently acrylic is applied bifrontally. The selection of one of these three approaches depends on three considerations: The severity of the deformity is the most significant factor in the selection of the procedure. In mild cases of frontal asymmetry, shaving of the protruding frontal bone contralateral to the fused half of the coronal sutures and acrylic augmentation of the recessed frontal bone ipsilateral to the fused coronal sutures corrects the appearance. However, in cases with more marked deformity, where the projection of the contralateral frontal bone exceeds the total thickness of the bone, the protruding section of bone is removed and the dura is plicated until the shape is normal. Acrylic is then applied bifrontally, substituting acrylic for the resected contralateral bone and augmenting the ipsilateral bone. In rare cases of extreme asymmetry in which a large volume of the contralateral brain must be displaced posteriorly by dural plications and the frontal bone region ipsilateral to the stenosed coronal suture remains significantly depressed, bifrontal osteotomy and on rare occasions release of the ipsilateral dura by fascia grafting is followed by insertion of a bifrontal acrylic implant. The second consideration, the thickness and condition of the frontal bone, affects whether and how much acrylic is required. If shaving off the outer table and diploe of the protuberant frontal bone contralateral to the stenosed coronal suture is insufficient to remove the frontal bossing and provide forehead symmetry, then the full thickness of the protuberant bone is removed and replaced by methyl methacrylate. Preoperative radiography will give a measure of bone thickness that may be safely removed. At the time of surgery, percussion of the remaining bone with the handle of a chisel will aid in judging the thickness and strength of remaining calvarial bone. Dural plication precedes the application of methyl methacrylate to create a flattening of the surface in the region where there had been excess projection. This is done to allow for the placement of a sufficiently thick and structurally sound acrylic plate. Alternatively, if the bone is lined with fissures, is very thin, or is so malformed as to make shaping impossible, acrylic is substituted for it without hesitation. In children under 3 years of age the use of acrylic across a vault suture line may restrict skull growth. Cranial bones grow primarily by the deposition of bone at sutural edges; crossing a growing suture with a bridge of acrylic may cause secondary deformities. In children over 3 years of age, limited, judicious placement of acrylic in regions of minimal growth is performed when indicated to maintain special features of contour, such as projection of the supraorbital rim area. Although contour remodeling occurs throughout the cranial bones in children, the supraorbital ridge develops relatively early, and does not grow significantly after early childhood. Acrylic onlay to this region is not likely to adversely affect the developing cranium. The above three considerations

determine our approach to correcting skull asymmetry associated with unilateral coronal synostosis in the child or the adult. Case Reports Case 1 This year-old woman had a history of facial deformities since childhood. This observation was confirmed by family photographs. Forehead asymmetry, deviation of her nose, and vertical orbital dystopia had become more noticeable with increasing age and were esthetically displeasing to her. She reported the psychological stresses of not having had correction of her deformity in childhood. Her medical history, including her prenatal history, was otherwise unremarkable. Examination Physical examination showed frontal and temporal region asymmetry with flattening of the left forehead; significant vertical dystopia, with the left orbit 4 mm higher than the right; and deviation of the nasal radix to the left Fig. Neurological examination was normal. Plain skull radiographs were diagnostic of left coronal synostosis. Preoperative appearance of the patient with forehead and periorbital asymmetry. Operation Under local anesthesia, a bicoronal incision was made and the anterior skin flap was reflected forward to the frontal nasal suture. Nasal osteotomies and transposition of the nasal radix to the midline were carried out Fig. Wire, secured to surrounding bone edges, was looped multiple times over the left cranial defect Fig. Methyl methacrylate was applied over the defect and wire scaffolding. Prior to complete polymerization, the acrylic was shaped over the cranial defect to augment the left frontal, temporal, and orbital regions for calvarial symmetry. The excessively prominent right frontal bone was recessed by burring down the outer table of the skull bone. Operative diagram showing the nasal osteotomies and transposition of the nasal radix. Operative diagram showing the method of securing the methyl methacrylate using wire scaffolding. Postoperative Course The patient exhibited mild nasal asymmetry. She also had a long-standing bilateral laxity of the eyelid skin. A nasal revision and an upperlid blepharoplasty were performed 3 years later. Six years postoperatively the frontal forehead area of the remains symmetrical. Absolute vertical dystopia is still present but has been satisfactorily masked by facial midline revision Fig. Case 2 This 5-year-old girl was the product of an uncomplicated pregnancy and normal vaginal delivery. Physical examination at birth was described as normal, except for the presence of congenital esotropia. Her family doctor noted asymmetry of the frontal regions at the age of 6 months, but skull films did not demonstrate sutural stenosis. Her congenital esotropia was treated with inferior oblique myomectomies and recession of the recti lateralis muscles at 13 months of age. Frontal skull asymmetry continued to become more prominent, and she was referred to the University of Virginia Craniofacial Anomalies Clinic at 3 years of age. Examination Examination revealed flattening of the left frontal portion of the forehead with recession of the supraorbital ridge, a shortened left lateral orbital wall, and moderate right frontal bossing Fig. The nasal radix was deviated to the left. The remainder of her physical examination was normal. A computerized tomography scan of the head did not reveal any intracranial pathology. Preoperative appearance of the patient showing flattening of the left forehead region. Operation Following adequate exposure of the frontal regions and orbital rims via a bicoronal incision, a right frontal craniectomy was performed. Upon removal of the bone flap, the brain and dura bulged outward. The dura was plicated to provide an optimal contour. Steel wire scaffolding anchored to the surrounding bone edges was placed over the left frontal defect and right frontal craniectomy. Methyl methacrylate onlay was applied over this wire scaffolding and allowed to polymerize. The acrylic was molded to augment the left frontal region and left orbital rim Fig. The contour of acrylic over the right frontal craniectomy was sculptured with a shaping burr to produce symmetry of the frontal areas. The deviated nasal bridge was reduced by nasal osteotomies and fixed in the midline with steel wire. Intraoperative view of acrylic augmentation of the hypoplastic left frontal region. The thickness of the bone in the right frontal region has been reduced by shaving. Postoperative Course Symmetry of the frontal, temporal, and supraorbital regions with only mild vertical dystopia was noted at 7 months after surgical correction. Discussion While the pathogenesis of unilateral coronal synostosis is unknown, the resulting deformity is always bilateral and has often been documented. This produces contralateral frontal bossing and a prolapse of the roof of the orbit and the supraorbital ridge. The excessive growth of the frontal bone on the contralateral side is associated with flattening or lack of development of the normal convexity of the supraorbital ridge on the side of suture stenosis. This increases the angle between the interpupillary and vertical facial midline planes. In these older patients, skull deformities must be corrected to normal adult dimensions. Tessier 22 recommends displacement and reshaping of both orbits, the nasoethmoid

complex, and the nasal pyramid, as well as bilateral frontal craniotomy. This procedure addresses the bilateral nature of the deformity and yields esthetically pleasing results, but entails a lengthy operative procedure. Because of the risks unavoidably accompanying such a major craniofacial operation, a quicker, safer, and less traumatic procedure is desirable for those patients with less severe deformity and good eye function who desire solely esthetic improvement. With the use of acrylic materials for vault reshaping, we are able to achieve results that are reliably superior to those we have achieved with any other technique. The operative procedures using the acrylic materials are shorter in duration and less invasive than other procedures using autogenous materials, thus further reducing both cost and operative risk. The traditional alternative for reconstruction of skull defects has been by autogenous bone grafts from the rib, iliac crest, or calvaria. Procuring bone from the rib or iliac crest requires a second operative site. The endochondral bone from rib or hip resorbs significantly more rapidly than does the membranous bone available in the calvaria. Zins and Whitaker 25 have shown that endochondral bone grafts resorb three and four times as fast as membranous bone grafts in rabbits and monkeys, respectively. Since resorption of endochondral bone grafts is both significant and unpredictable, this type of bone is less suitable for reconstructing such a highly visible area of the cranium as the forehead. Membranous bone from the parietal or frontal bones may be harvested through the same bicoronal incision needed to correct the unilateral coronal synostosis vault deformities. However, even membranous bone grafts have significant drawbacks as reconstructive materials. Compared to methyl methacrylate, suitable bone of appropriate thickness is much more difficult to obtain and to shape. Also, membranous bone grafts do resorb. Although they advocated membranous bone use, Zins and Whitaker 25 found volume decreases of We have already observed major absorption of calvarial bone grafts in humans, with no clinical evidence of sepsis or other complications that might account for the loss of bone. While this resorption is far less than endochondral graft resorption, it is unpredictable and can cause significant structural and esthetic defects. Methyl methacrylate was chosen from a selection of possible metallic, synthetic, and biogenic reconstructive materials. Implants of stainless steel, Vitallium, and tantalum, 12 which have commonly been placed in the cranium, provide protection for the brain, but their rigidity makes them unsuitable for molding the fine contours necessary in craniofacial reconstruction.

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4: Craniofacial Surgery - Google Books

For the orbital level (transversal plane) it may be assumed that the right paramedian cleft (type 13) caused right orbital dystopia which will contribute to an increasing interorbital distance with further growth and will aggravate the effects of the coexistent median malfusion (type 14).

Sclerotherapy for Varicose Veins Sclerotherapy treats Varicose Veins and Spider Veins Sclerotherapy is a non-surgical, injection-based therapy that improves the appearance of varicose veins in the legs. The procedure involves the injection of a solution into spider veins smaller, red-purple in color , and reticular veins larger, blue-green , causing disruption to the internal lining of the vein. A very fine needle is used to inject the sclerosing solution into the vein with only very minimal discomfort. How does Sclerotherapy Work? During your initial consultation, your legs will be examined thoroughly. The sclerotherapy treatment usually takes approximately 30 minutes. This is followed by placement of compression dressings if needed. In some cases, support stockings are recommended for up to one week after each treatment. How Long Does it Take to Heal? It is normal for the treated area to look worse before improvement is seen. Support stockings are used to reduce cosmetic downtime, improve healing times, and prevent recurrence of small vessels after treatment. After your initial sclerotherapy treatment, the treated veins will fade in appearance within a few weeks, but often it may take up to a month to see full results. Multiple treatments are usually required to achieve the desired outcome. Treatments are spaced 6 weeks or more apart to allow complete resolution of the veins treated during the previous session. Pre-Treatment Recommendations If possible, prior to treatment, avoid anticoagulant medications, including Ibuprofen, Motrin, and Aspirin. Avoiding alcohol prior to treatment may reduce bruising. Avoid sun exposure prior to treatment for at least weeks and for an additional weeks after treatment. Post-Treatment Procedures Be sure to wear the compression stockings for a full week after the treatment procedure. Wear the stockings continuously for the first 48 hours, removing only for a quick, lukewarm shower once daily. After the initial 48 hours, wear the stockings daily, from the time you rise in the morning, until bedtime. You may wash the stockings with a gentle detergent and allow them to dry overnight. Do not put them in the dryer. After the first week, we recommend that patients who stand for long periods of time or spend long hours on their feet continue to wear the stockings during those times. Itching will typically subside after a few hours. To help ease itching or discomfort, we recommend cool packs or a soothing gel. Avoid sun exposure for an additional weeks after treatment. If sun exposure cannot be avoided, a physical sunblock that includes titanium dioxide or zinc oxide must be used. Sun exposure may exacerbate occasional pigmentation, causing it to last longer. Most patients experience bruising that lasts approximately weeks after each treatment. This is followed by some mild pigmentation that can persist for a few weeks to up to a few months after each treatment. We will discuss this with you in order to plan your treatments accordingly. For the first hours after each treatment , please avoid the following: Aerobic or strenuous exercise. Although gentle walking is recommended and helps with the healing process. Avoid hot showers and baths for hours after treatment. Quick, lukewarm showers are recommended. Who Performs The Sclerotherapy Procedure? Deschamps-Braly is on hand to consult in more complex cases if necessary.

5: Craniofacial surgery (edition) | Open Library

Orbital hypertelorism; Multiblock osteotomy; Paramedian resection; Visual function; Binocular vision Summary Orbital hypertelorism is deï¬•ned as an abnormally wide bony interorbital distance. The aims of surgery are both correction of ocular dystopia and cosmetic reconstruction of the nasal crest.

6: Sclerotherapy for Varicose Veins: Non-Surgical, Injectable Treatments

19 Raposo-Amaral CE, Raposo-Amaral CM, Raposo-Amaral CA, Chahal H, Bradley JP, Jarrahy R. Age at surgery significantly impacts the amount of orbital relapse following hypertelorbitism correction: a year longitudinal study.

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7: - NLM Catalog Result

ing to inferior displacement of the medial canthi, resulting in either vertical orbital dystopia or telecanthus. A lower eyelid coloboma, medial to lacrimal punctum.

8: Table of contents for Craniofacial surgery

Part II: Patient with severe orbital dystopia (81mm intradacyron distance), laterally oriented orbits and anteriorly displaced frontal lobes underwent gradual orbital contraction over 14 days following facial bipartition and removal of abnormal medial bony interferences.

9: Surgical approach of hypertelorbitism in craniofrontonasal dysplasia

Enquire about the mechanism of injury; zygoma fractures usually occur after blunt trauma. Altogether, % of patients will complain of infra orbital/upper lip numbness on the affected side. This may involve the maxillary central, lateral, and/or canine teeth.

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