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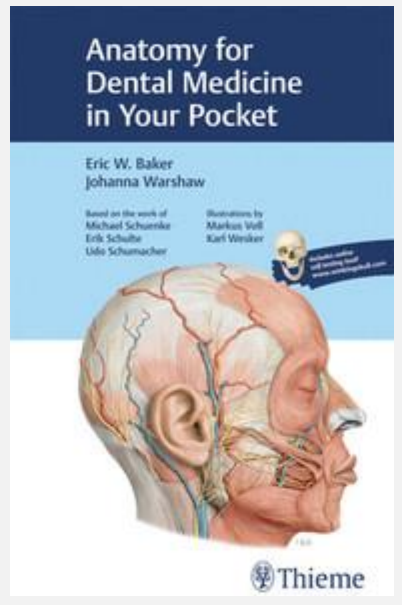

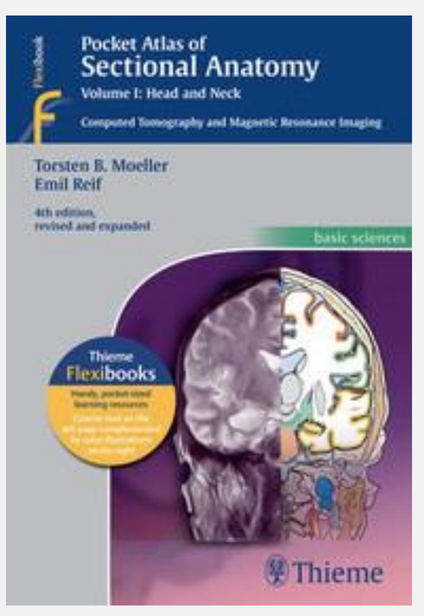

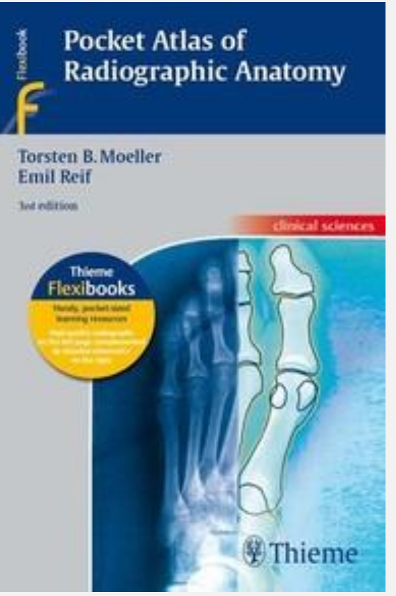

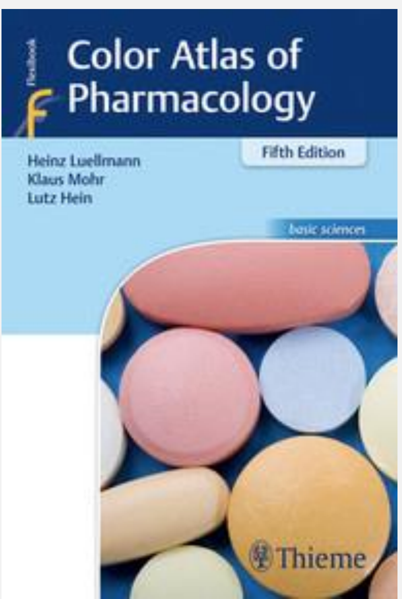

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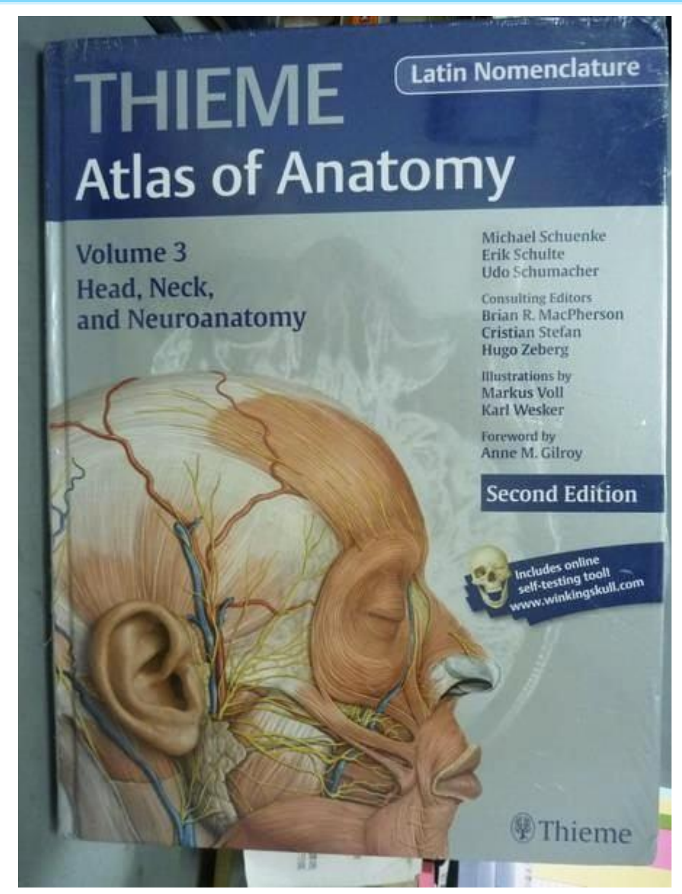

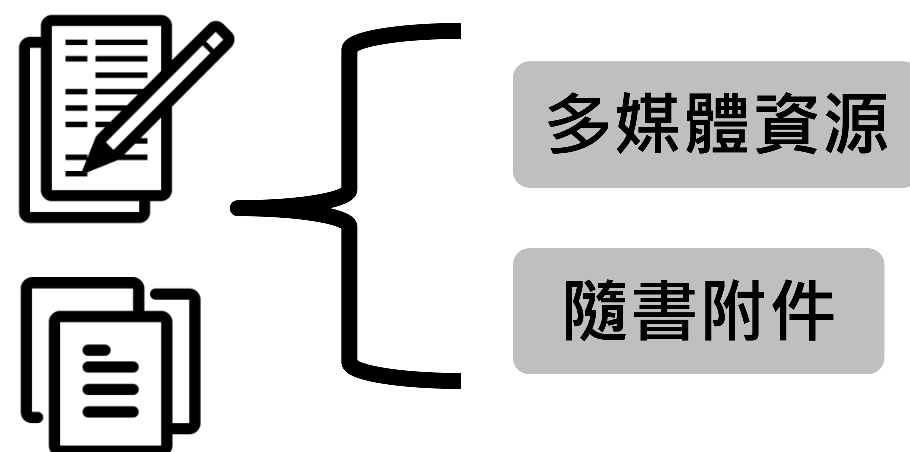

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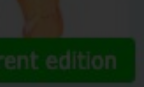
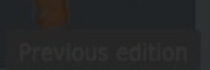

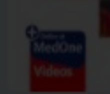
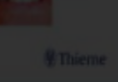

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三、四年級：整合性基礎醫學教育

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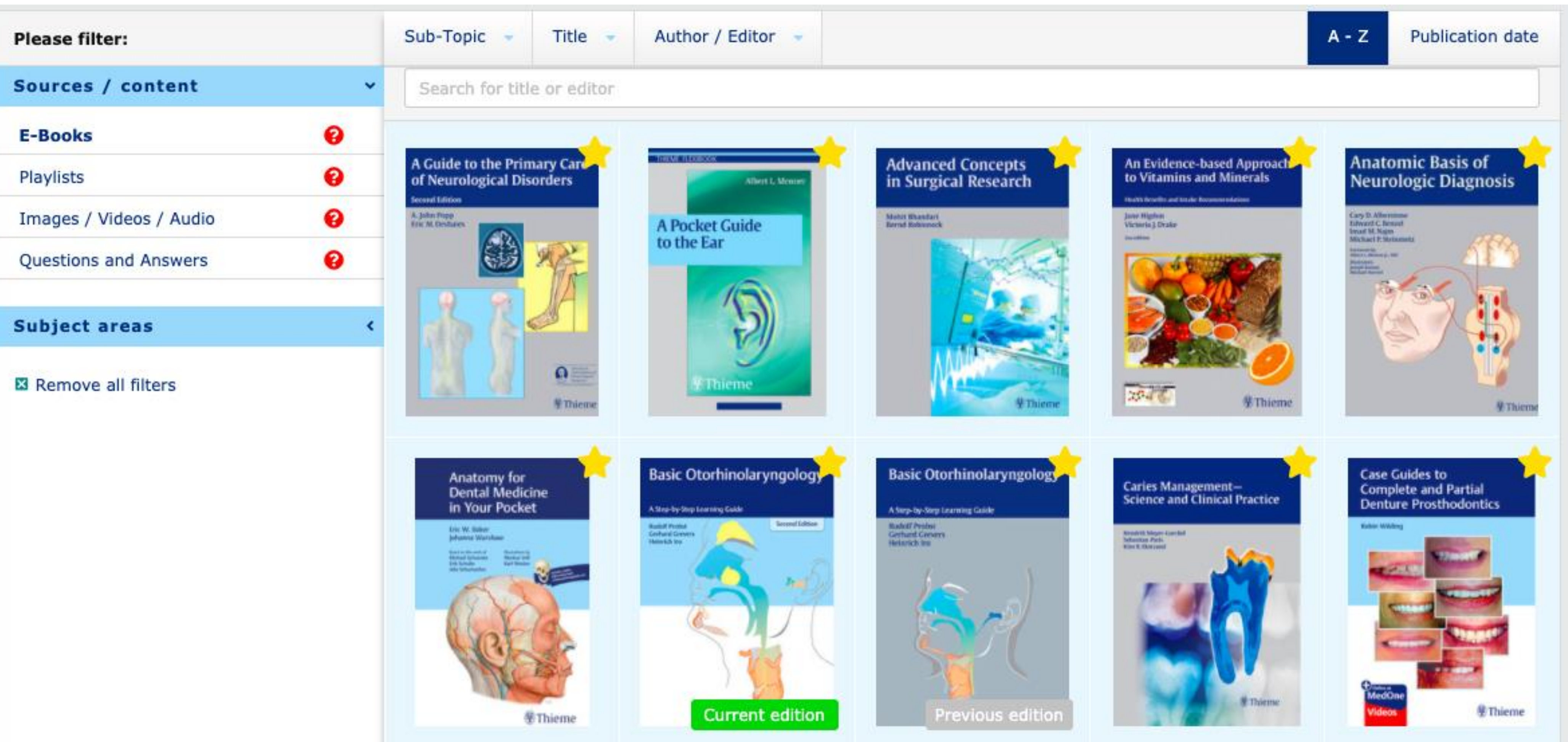

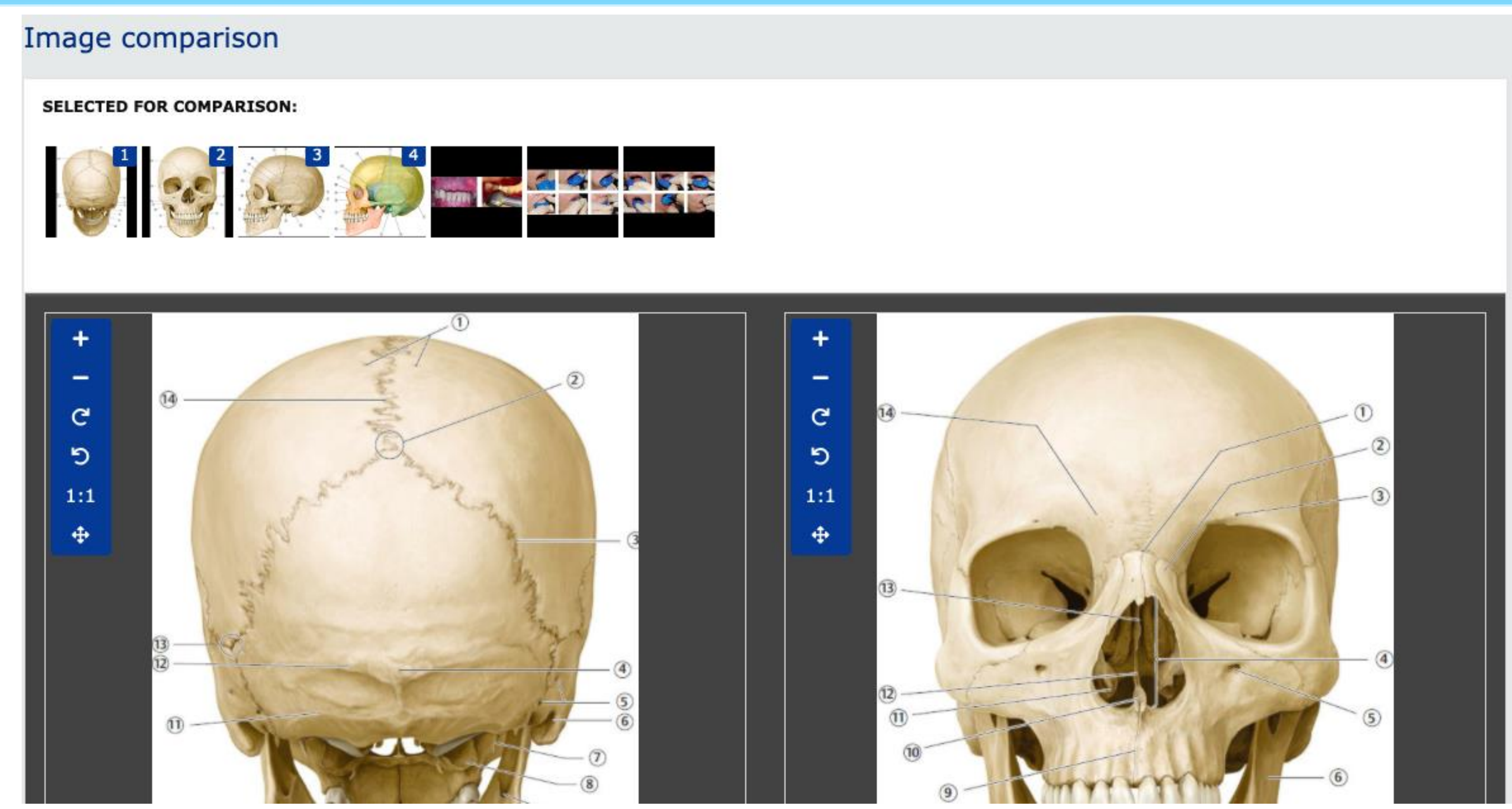

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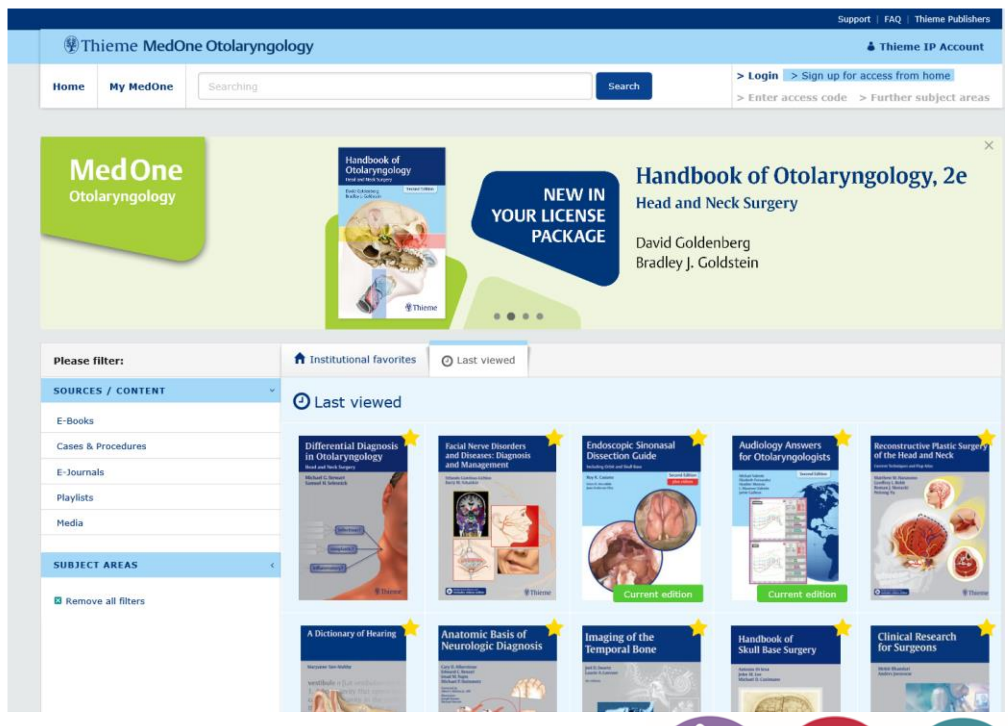

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L. Maureen Valente, Jamie Cadieux

Audiology Answers for Otolaryngologists

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Source: Valente L, Cadieux J, ed. 2nd Edition. Thieme; 2017. doi:10.1055/b-006-149768

完整章節目錄

與檢索詞彙相關的圖片

書中與檢索詞彙相關的文字內容

Content | Images | Hits

1 Psychoacoustics
2 Audiometric Testing
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1 Psychoacoustics

1 Psychoacoustics

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What Is the Difference between dB HL and dB SPL?|What Is the Difference between dB IL and dB SPL?|What Is the Difference between Detection and Discrimination?|What Is the Minimum Audible Angle?|What Psychoacoustic Properties Influence Sound Localization?|What Is Loudness Recruitment?|What Is Frequency?|What Is Fundamental Frequency and What Are Harmonics?|How Does the Frequency Spectrum of Vowels versus That of Consonants Influence Speech Recognition?|What Is the Upward Spread of Masking and How Does It Impact Speech Recognition? |What Is the Just Noticeable Difference for Intensity and Frequency?|What Are the Advantages of Binaural versus Monaural Hearing?|References

What Is the Difference between dB HL and dB SPL?

The **decibel** (**dB**) is a logarithmic unit of measurement used to express the magnitude of a sound relative to some reference level. Decibels in hearing level, or **dB HL**, is commonly used in audiology because it refers to the dB level on the audiometer. The reference level for dB HL is "0," which is related to the average threshold in decibels sound pressure level (dB SPL) for the average, normal-hearing listener. In Fig. 1.1, the solid black line represents the average auditory threshold in dB SPL at each audiometric frequency. Each threshold in dB SPL, which is noted in the table at the bottom of Fig. 1.1, is equal to 0 dB HL on the audiometer for the corresponding frequency.

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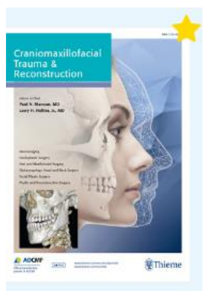

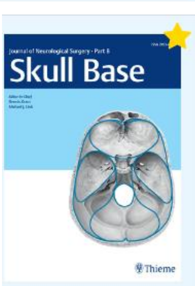

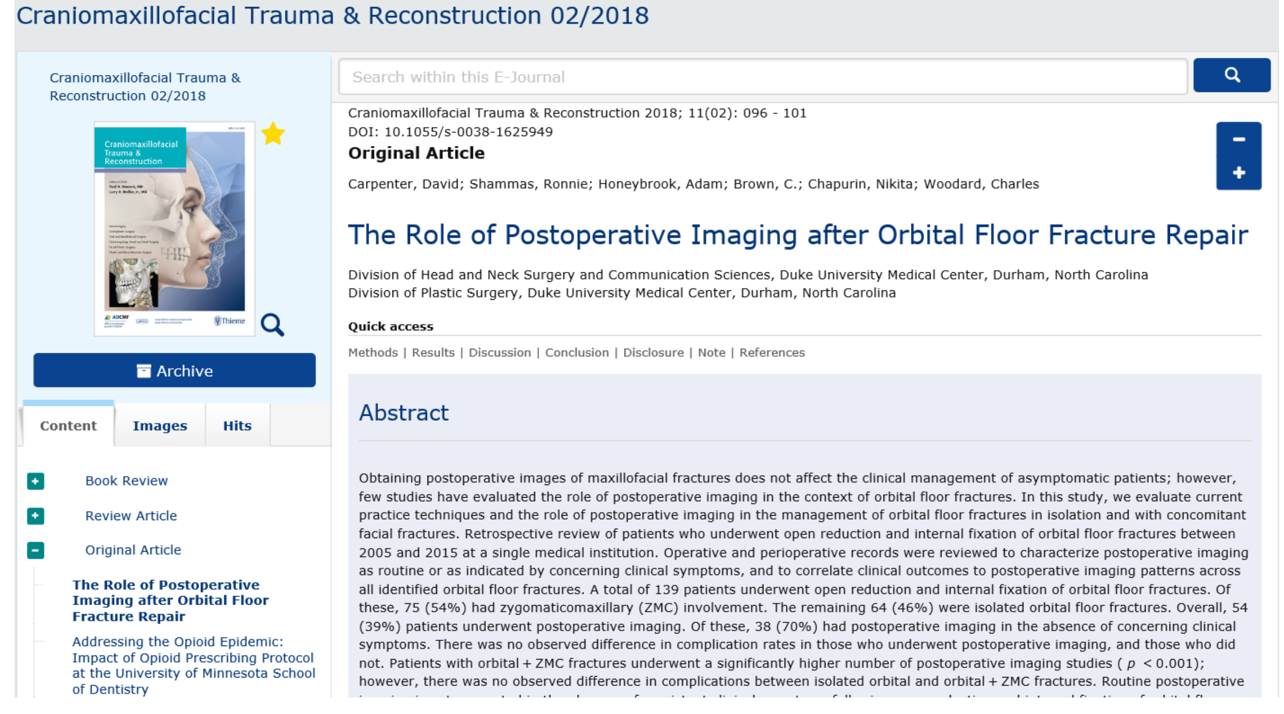

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收錄上百件案例的管理與追蹤提示

Tonsillitis

Case

Source: Pensak M, ed. Otolaryngology Cases. The University of Cincinnati Clinical Portfolio.. 2nd Edition. Thieme; 2017. doi:10.1055/b-006-149761

66 Tonsillitis
- 66.1 History
- 66.2 Differential Diagnosis—Key Points
- 66.3 Test Interpretation
- 66.4 Diagnosis
- 66.5 Medical Management
- 66.6 Surgical Management
- 66.7 Rehabilitation and Follow-up
- 66.8 Questions
- Suggested Readings

Part XI General Otolaryngology > 66 Tonsillitis

Tonsillitis

Andrew J. Redmann and Reena Dhanda Patil

Quick access

66.1 History|66.2 Differential Diagnosis—Key Points|66.3 Test Interpretation|66.4 Diagnosis|66.5 Medical Management|66.6 Surgical Management|66.7 Rehabilitation and Follow-up|66.8 Questions|Suggested Readings

66.1 History

A 51-year-old man presented to the emergency department with a 2-day history of low-grade fever, worsening sore throat, odynophagia, right otalgia, and muffled voice. He denied any difficulty breathing or handling his oral secretions. He had similar symptoms 3 years ago and was diagnosed with a peritonsillar abscess. This was drained in the emergency department. Additionally he reported approximately three episodes of pharyngitis per year for the last 3 years. These had all been treated with antibiotics, which improved his symptoms. His medical history was significant for gastroesophageal reflux disease (GERD) and obstructive sleep apnea, which resolved following an intentional 40-lb weight loss. He was a prior three-pack-per-day smoker but currently only smoked eight cigarettes per day.

Physical exam revealed an adult man in no acute distress. Temperature was 101.1 °F. All other vital signs were within normal limits. Ear and nasal exams were normal. Intraoral examination revealed erythematous oropharyngeal mucosa. Tonsils were 1 + bilaterally, with the right tonsil appearing slightly larger than the left tonsil. There was no uvular deviation or soft palate fullness (▶ Fig. 66.1). Neck examination revealed bilateral shotty lymphadenopathy but full range of motion.

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Deep Tongue Abscess

Procedure

Source: Theissing J, Rettinger G, Werner J, ed. ENT Head and Neck Surgery: Essential Procedures. 1st Edition. Thieme; 2010. doi:10.1055/b-002-79384

- Deep Tongue Abscess
  - Surgical Principle
  - Anesthesia
  - Surgical Technique
  - Postoperative Care

9 Surgery of the Oral Cavity and Oropharynx > Surgery for Abscesses of the Oral Cavity > Deep Tongue Abscess

Jürgen Theissing, Gerhard Rettinger, Jochen Alfred Werner

Deep Tongue Abscess

Quick access

Surgical Principle|Anesthesia|Surgical Technique|Postoperative Care

Surgical Principle

Incision and drainage always from an external approach.

Anesthesia

Usually general endotracheal anesthesia.

Surgical Technique

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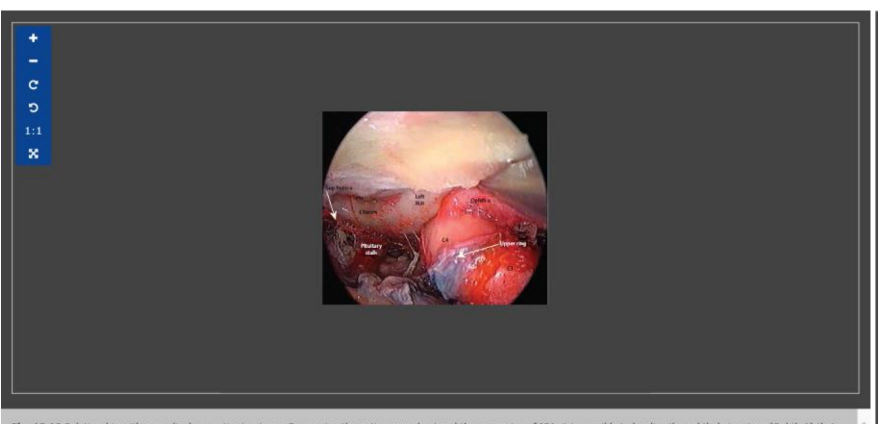


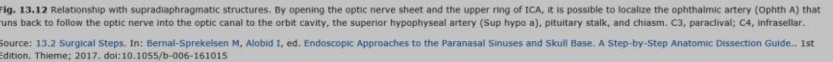
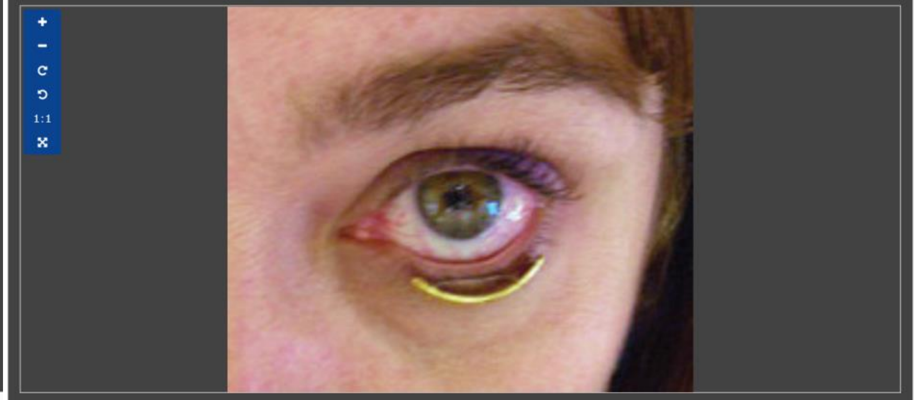


Fig. 13.12 Relationship with supradiaphragmatic structures. By opening the optic nerve sheet and the upper ring of ICA, it is possible to localize the ophthalmic artery (Ophth A) that runs back to follow the optic nerve into the optic canal to the orbit cavity, the superior hypophyseal artery (Sup hypo a), pituitary stalk, and chiasm. C3, paraclival; C4, infrasellar.

Source: 13.2 Surgical Steps. In: Bernal-Sprekelsen M, Alobid I, ed. Endoscopic Approaches to the Paranasal Sinuses and Skull Base. A Step-by-Step Anatomic Dissection Guide.. 1st Edition. Thieme; 2017. doi:10.1055/b-006-161015



This patient with a normal tarsoligamentous sling developed a simulated ectropion after a 2.8 g gold weight was taped to her lower lid. This demonstrates that very little downward force after a blepharoplasty from swelling and scar contracture can cause an ectropion.

Source: Lower Lid Blepharoplasty. In: Codner M, McCord C, ed. Eyelid & Periorbital Surgery. 2nd Edition. Thieme; 2016. doi:10.1055/b-005-148980

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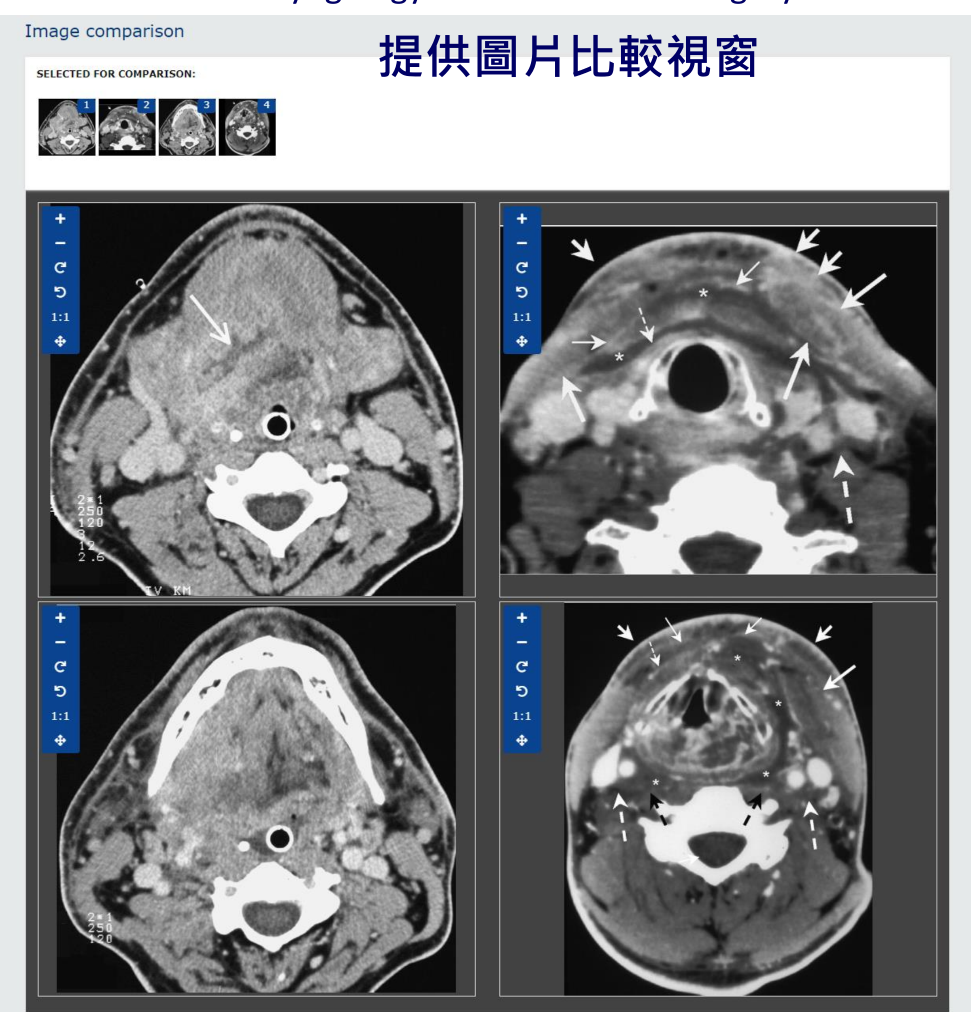

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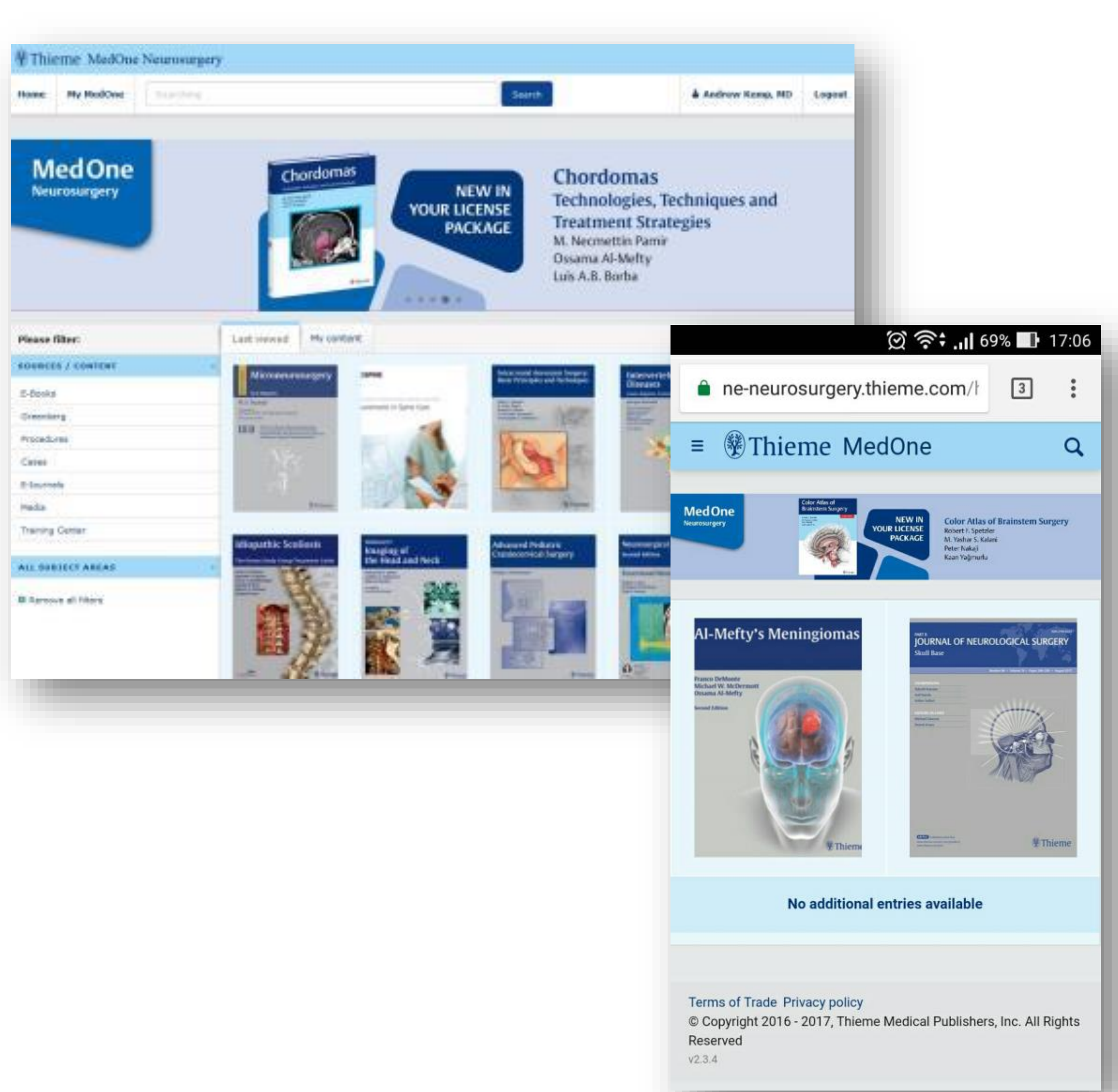

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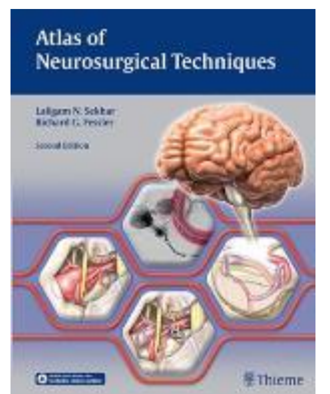
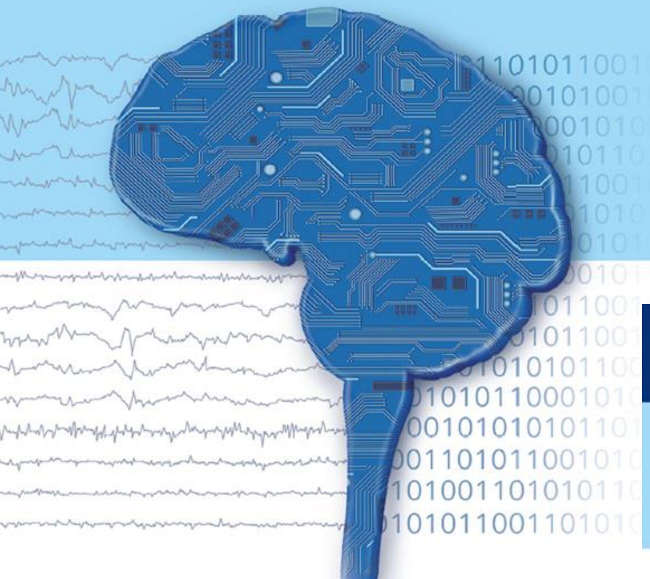


Mark S. Greenberg



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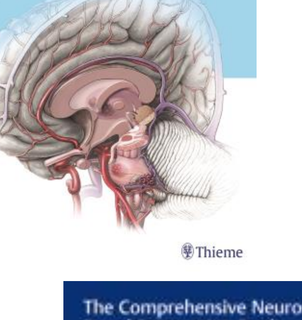

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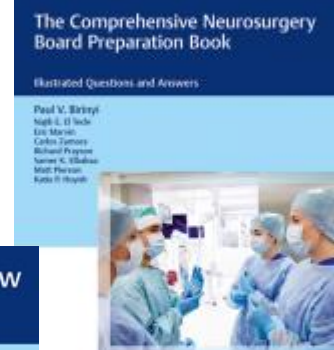

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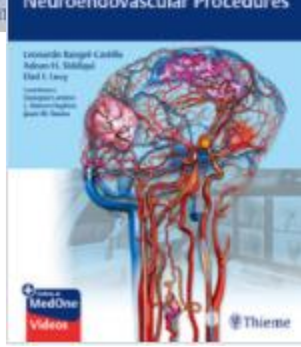
For Daily Clinical Use and Oral Board Preparation

Vasilios A. Zerris



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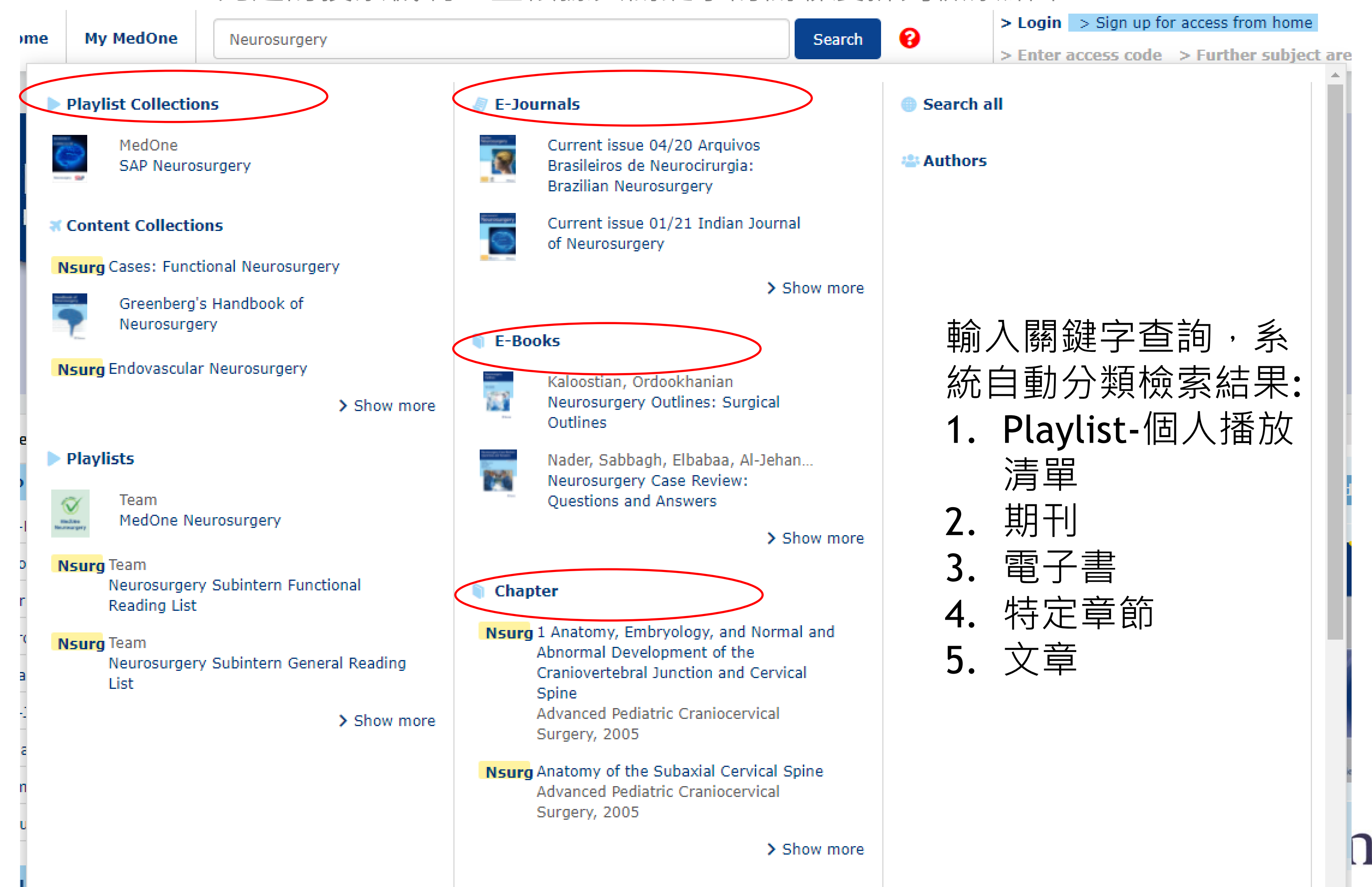

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Endoscopic Approach to Craniopharyngioma

Nancy McLaughlin, Leo F. S. Ditzel Filho, Daniel M. Prevedello, Daniel F. Kelly, Ricardo Carrau, Amin Kassam

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Introduction and Background | Operative Detail and Preparation | Outcomes and Postoperative Course | References

Introduction and Background

Definition, Pathophysiology, Epidemiology, and Histology

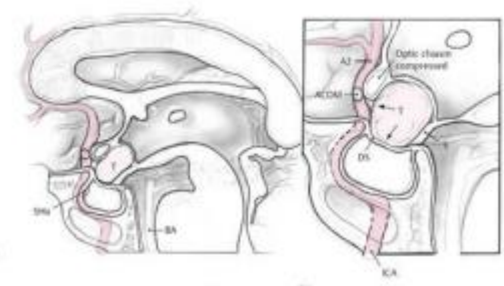
- Craniopharyngiomas are rare tumors of the central nervous system that occur at a rate of 1.3 per million person-years. Overall, they account for 2–5% of all primary intracranial neoplasms. Although they can be diagnosed at any age, craniopharyngiomas typically present a bimodal age distribution with a first peak in children 5–14 years old and a second peak in adults 50–74 years old.
- Craniopharyngiomas arise along the path of the craniopharyngeal duct, a canal connecting the stomodeal ectoderm with the evaginated Rathke pouch. Some authors have proposed that these tumors arise from neoplastic transformation of embryonic squamous cell rests of the involuted craniopharyngeal duct. Others have suggested that craniopharyngiomas result from metaplasia of adenohypophyseal cells in the pituitary stalk or gland.
- Craniopharyngioma are benign grade I tumors according to the World Health Organization classification. Histologically, two subtypes have been recognized, the adamantinomatous (most common, predominantly in young patients) and the papillary (almost exclusively in adults). Transitional or mixed forms have also been reported.
- Despite its benign histology, craniopharyngiomas tend to adhere and infiltrate surrounding structures. This characteristic accounts for their aggressive behavior and potentially significant morbidity and mortality. Rarely, craniopharyngiomas may present a malignant transformation, potentially and questionably induced by radiation therapy.

Clinical Presentation

- As craniopharyngiomas grow within the sellar/parasellar region, they may exert mass effect on critical structures of the nervous system including the optic apparatus, pituitary stalk and gland, floor of the third ventricle, hypothalamus, and cerebral vasculature of the circle of Willis.
- Headache, nausea/vomiting, visual disturbances, and symptoms related to hypothalamopituitary dysfunction are among the most commonly reported clinical manifestations. Less common presenting features include motor weakness, seizures, psychiatric symptoms, autonomic disturbances, and precocious puberty.
- Symptomatic elevated intracranial pressure may occur in any age population, resulting from obstruction of the foramen of Monro or of the aqueduct of sylvius by the tumor.

Staging

- To date, authors have proposed various classification systems depending on their relation to the sella turcica, diaphragm sellae, optic chiasm, and third ventricle. The infundibulum is the key anatomic landmark that helps guide the modular exposure of endoscopic endonasal approaches (EEA) for craniopharyngioma resection (Fig. 60.1), as previously described by Kassam et al.
- *Type I craniopharyngiomas* are preinfundibular, located immediately anterior to the pituitary stalk (most accessible). They are located in the suprasellar space, guarded inferiorly by the diaphragm, superiorly by the displaced chiasm, posteriorly by the pituitary stalk, and laterally by the carotid arteries. Preinfundibular lesions are the most direct craniopharyngiomas to approach through an endonasal route.
- *Type II craniopharyngiomas* are transinfundibular lesions that grow within the long axis of the infundibulum, widening it circumferentially. Such lesions often create a component in the subchiasmatic space and extend rostrally through the tuber cinereum and into the third ventricle. In these cases, the stalk forms the capsule of the tumor.
- *Type III craniopharyngiomas* are retroinfundibular lesions, located posterior to the pituitary stalk (most challenging). They are bounded anteriorly by the pituitary stalk and posteriorly by the mamillary bodies and basilar apex. The tumor may extend rostrally (type 3a), through the membrane of Liliequist, to ultimately encroach or invade the third ventricle. It may also extend caudally (type 3b) to fill the interpeduncular fossa, potentially encroaching on the posterior circulation. Laterally, retroinfundibular craniopharyngiomas are bounded by the oculomotor nerves as they travel forward toward the cavernous sinus and the posterior communicating arteries as they travel between the posterior cerebral artery (P1) and the internal carotid artery (ICA).
- *Type IV craniopharyngiomas* are pure intraventricular tumors. These tumors may best be approached by a transcranial route as the endonasal corridors are often limited by the stalk and chiasm.



Cases: 收錄225個案子的管理與追蹤提示

Brain Abscess

Pedro M. Ramirez and Martina Stippler

Quick access

Case Presentation | Questions | Overview | Answers | Summary | Annotated References

Case Presentation

A 52-year-old man with no previous medical history was brought to the emergency department with tonicoclonic seizure on the right side. The patient was afebrile, postictal at examination, but had no focal neurological deficit. He had a history of alcohol abuse (12-pack of beer a day). Laboratory workup showed: white blood cell (WBC) count 18.6 × 103 (neutrophil 91%); erythrocyte sedimentation rate (ESR) 10 (0–25); C-reactive protein (CRP) 1.4 (< 0.3), and blood glucose is 148 mg/dL. Noncontrast computed tomographic (CT) scan and enhanced magnetic resonance imaging (MRI) were obtained (Fig. 140.1). Blood cultures were negative and the patient is started on empirical antibiotic therapy. Two weeks after empirical therapy was the patient continued having headaches, the WBC count was 3.4 × 103, ESR was 15, and CRP was 0.5. A follow-up MRI scan was obtained (Fig. 140.2). The patient undergoes stereotactic needle aspiration, which showed a positive culture for *Nocardia*. Antibiotic therapy was titrated with ceftriaxone for 6 weeks and trimethoprim/sulfamethoxazole for 12 months.

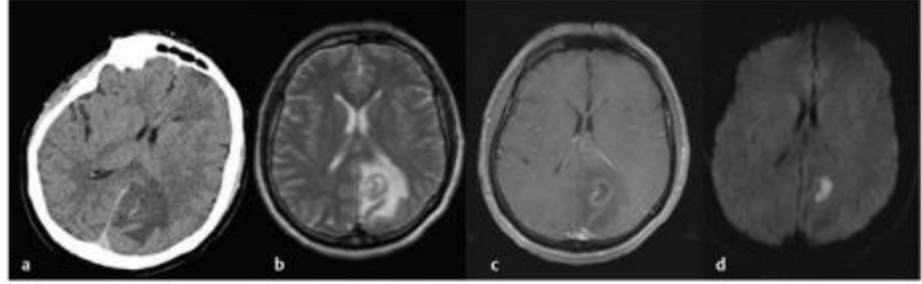
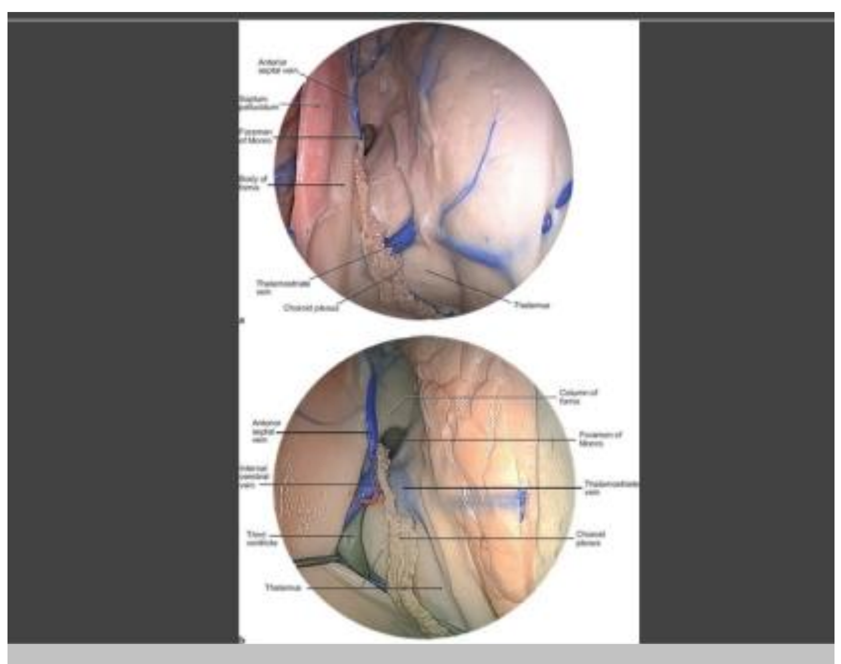


Fig. 140.1 Imaging studies at the time of admission. (**a**) Computed tomographic scan without contrast showing left parietal edema with a central rim. (**b**) T2-weighted magnetic resonance imaging (MRI) demonstrating the hyperintense lesion in the left parietal lobe with surrounding vasogenic edema. (**c**) Contrast-enhanced T1-weighted MRI demonstrating a left parietal ring-enhancing lesion. (**d**) Diffusion-weighted imaging revealing restricted diffusion.

Images/Videos/Audios

95,361 包含圖註影像



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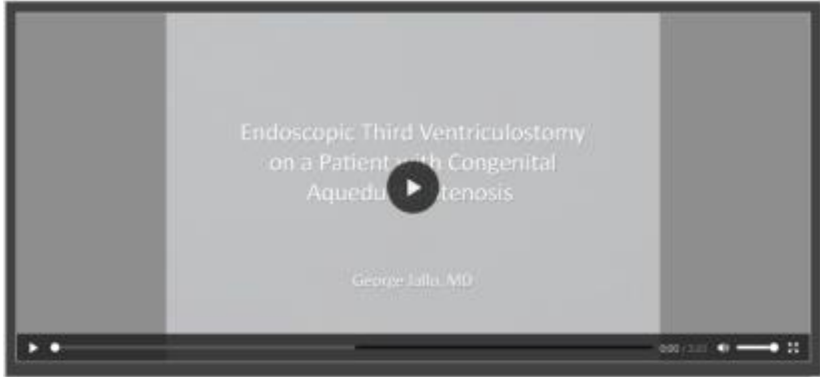

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Questions and Answers

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Treatment

Statsitics of learning progress

1788 /2387

Question

Answer

Question 1788

True or False. Patients who undergo decompressive laminectomies are likely to develop lumbar instability?

Answer

True or False. Patients who undergo decompressive laminectomies are likely to develop lumbar instability?	false - Less than 1%	Greenberg 8th edition, Chapter 72.8.4

Correctly answered   repeat

‹ Previous question   Next question ›

Source:

Treatment

From:: The Greenberg Rapid Review: A Companion to the 8th Edition

Short link: https://medone-neurosurgery.thieme.com/N7E87

E-Journals: 可閱讀期刊全文內容

閱讀電子書

Alan R. Cohen

Pediatric Neurosurgery

檢索詞

ischemic stroke

Pediatric Neurosurgery 2015: 1st Edition

Content | Images | Hits

Section I Introduction
1 Basic Surgical Technique
2 Diagnostic Procedures
3 Neuroanesthesia
4 Pre- and Postoperative Management of the Neurosurgical Patient
5 Pediatric Neurosurgical Positioning
6 Intraoperative Neurophysiological Monitoring During Pediatric Neurosurgical Procedures
7 Surgical Safety
Section II Neurology
8 Neonatal Neurologic Examination
9 Neurologic Examination of the Child and Adolescent
Section III Congenital Malformations
Section III.A Malformations of the Scalp and Skull

完整目錄

圖解文字包含到檢索字詞的相關圖片

檢索詞相關的章節

Section I Introduction

調整字體大小

Section I Introduction

Section Editor: Tae Sung Park

This section covers a wide range of fundamental issues in pediatric neurosurgery and contains seven chapters. Chapter 1, "Basic Surgical Technique," provides steps of preoperative and operative planning and execution of surgery in the operating room. Dr. Cohen, the editor of this textbook, emphasizes the importance of sound surgical judgment, setting the tone in the operating room, and the goal of getting the patient safely and expeditiously through the surgery and out of the operating room. Other operative details of neurosurgery are also provided. Chapter 2 addresses common diagnostic and therapeutic procedures: assessment of shunts, lumbar puncture, external ventricular catheter placement, and subdural taps. In addition to operative detail and preoperative planning, the authors describe the equipment needed and provide expert suggestions. Chapter 3 covers important areas of pediatric neuroanesthesia, such as special equipment, vascular access and positioning, management of fluids, and blood loss. The authors also address the anesthetic considerations for specific neurosurgical procedures. Chapter 4, "Pre- and Postoperative Management of the Neurosurgical Patient," starts with a review of cerebrovascular and CSF physiology. It ends with a review of common clinical problems in the perioperative period, such as causes of delayed emergence from anesthesia, choice of intravenous fluids for different age groups, and management of hyponatremia and hypernatremia. Chapter 5 is devoted to the positioning of children during surgery. It includes descriptions of special cautions in rigid cranial immobilization, supine positioning for specific common operative procedures, prone positioning for tumor surgery, and lateral positioning for lumboperitoneal shunt and baclofen pump insertion. Chapter 6 addresses intraoperative neurophysiological monitoring in children. It not only provides details of various monitoring techniques, but also discusses tailored monitoring for specific procedures. Chapter 7 addresses surgical safety. The chapter focuses on three major and related strategies derived from highly reliable organizations, which have gained widespread acceptance: the development of a culture of safety, the creation of effective surgical teams, and the use of communication support tools—specifically, checklists and handoff scripts in patient care. This section, then, provides the reader with a comprehensive overview of basic principles that should be followed for the practice of safe and successful pediatric neurosurgery.

Source:

Section I Introduction

From: Pediatric Neurosurgery

All | E-books

RELATED CONTENT

其他電子書有關資訊。

Critical Illness of Patients with CNS Tumors
Tumors of the Pediatric Central Nervous System > Section I Current Therapeutic Strategies > Chapter 10 Critical Care > Critical Illness of Patients with CNS Tumors

57.3 Outcomes and Postoperative Course
Pediatric Neurosurgery > Section VI.A Supratentorial Neoplasms > 57 Tumors of the Optic Pathway and Hypothalamus > 57.3 Outcomes and Postoperative Course

3.2 Operative Detail and Preparation
Pediatric Neurosurgery > 3 Neuroanesthesia > 3.2 Operative Detail and Preparation

Ventriculoperitoneal Shunts
Controversies in Pediatric Neurosurgery > I Intracranial > 3 Noncommunicating Hydrocephalus > Ventriculoperitoneal Shunts

Blood component therapy
Handbook of Neurosurgery > General and Neurology > Hematology > Blood component therapy

90.2 Acute Pain in Children
Pediatric Neurosurgery > 90 Interventions for Acute and Chronic Pain in Children > 90.2 Acute Pain in Children

General Principles of Fever Management
Neurosurgical Infectious Disease, Surgical and Nonsurgical Management > V Special Populations > 19 Systemic Infections in the Neurologic

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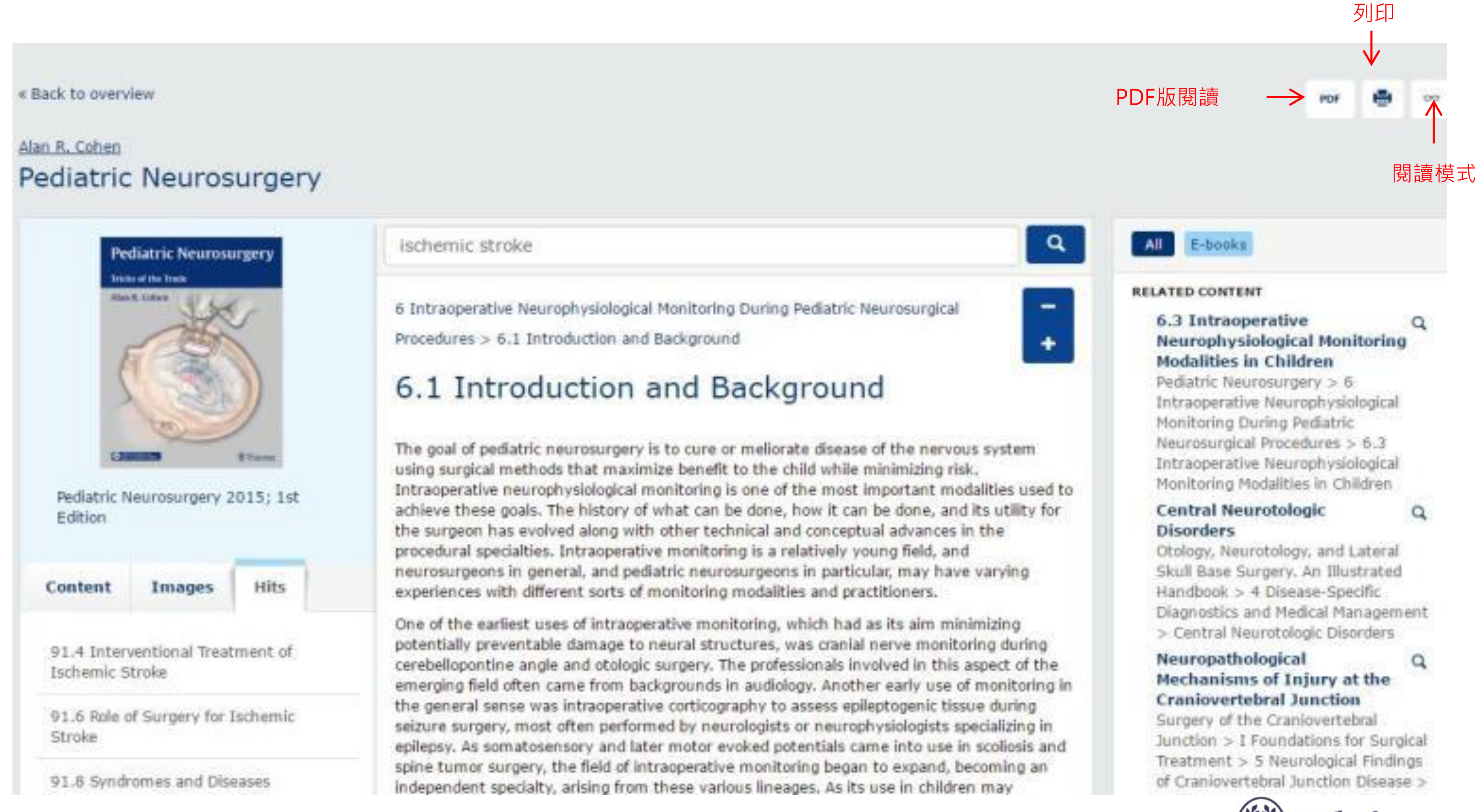

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Jamie S. Ullman, Patricia B. Raksin

Atlas of Emergency Neurosurgery

Atlas of Emergency Neurosurgery
2015; 1st Edition

Content | Images | Hits

I Cerebral Trauma and Stroke

1 Surgery for Epidural and Subdural Hematomas

2 Chronic Subdural Hematomas

3 Surgery for Cerebral Contusions of the Frontal and Temporal Lobes, Including Lobar Resections

4 Decompressive Craniectomy for Intracranial Hypertension and Stroke, Including Bone Flap Storage in Abdominal Fat Layer

5 Surgery for Cerebellar Stroke and Suboccipital Trauma

6 Elevation of Depressed Skull Fractures

Search within this E-book

I Cerebral Trauma and Stroke > 7 Invasive Neuromonitoring Techniques > Closing

Closing

- The incision site is irrigated. The skin incision is closed with 3.0 nylon sutures.
- A sterile transparent dressing is placed over the incision site (or around the bolt apparatus).
- Calibration
  - **EVD:** after catheter placement, the drain height is selected (in cm H_2O). The drainage system is set with the zero point level to the top of the patient's ear. This corresponds to the approximate level of the foramen of Monro—the midpoint of the ventricular system. The pressure waveform may be recorded by attachment to an external strain gauge or by insertion of a fiberoptic pressure probe or micro strain gauge device into the EVD lumen (and connection to a stand-alone monitor box).
  - **Parenchymal ICP monitor:** the fiberoptic pressure probe is attached to a stand-alone monitor box and zeroed with respect to air prior to insertion into the seated bolt apparatus.
  - **Brain tissue oxygen monitor:** Calibration is achieved through the use of a smartcard.
  - **Cerebral blood flow monitor:** To ensure that the probe is optimally placed, the K value on the monitor should be between 4.8 and 5.6 and the probe position assistant (PPA) below 2. The K value varies depending on the conductivity of the tissue. The K value of white matter is between 4.8 and 5.9. PPA indicates the artifact created by the pulsation of the brain tissue (if the probe is close to a vessel). A value of 0 indicates no artifact.
  - **Jugular venous saturation monitor:** Once correct probe position has been verified, light intensity calibration of the oximetry system can be performed. A blood sample from the tip of the catheter is also sent for analysis to confirm the value on the oximetry system. Frequent recalibration is required and should be prompted by any sudden change in the jugular venous saturation—prior to any alteration of medical management.

Source:

Closing

From: *Atlas of Emergency Neurosurgery*

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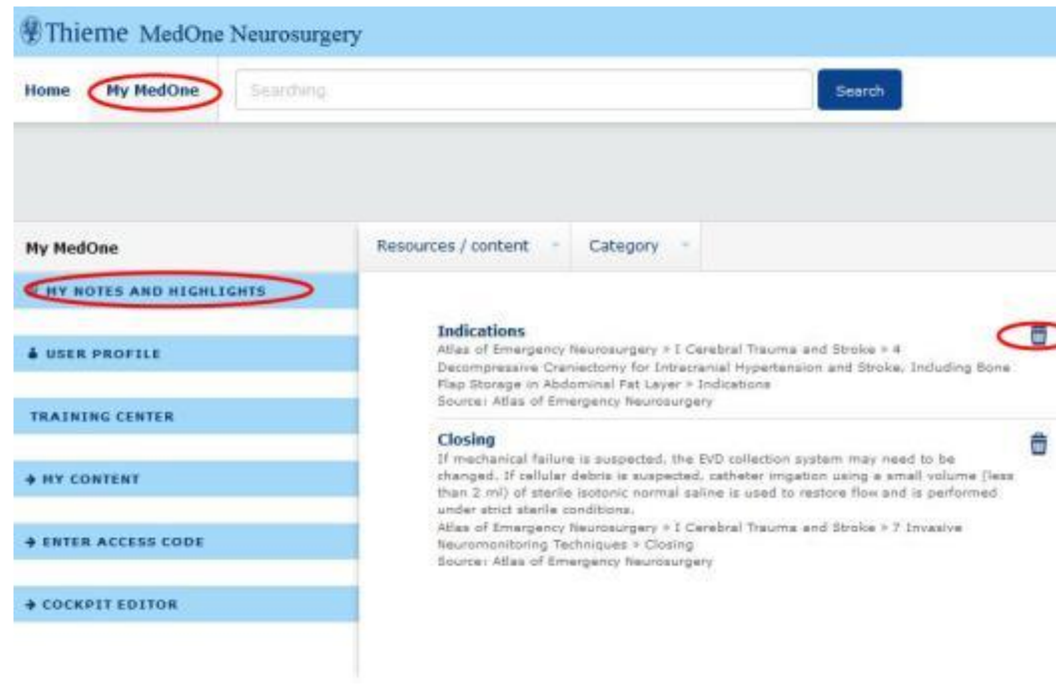

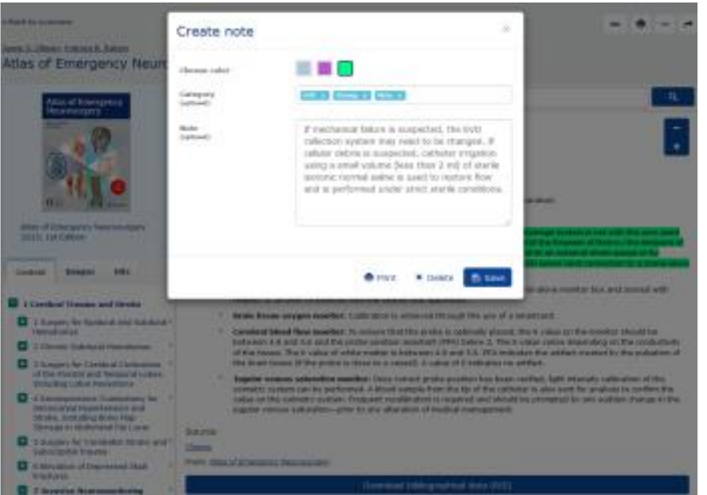

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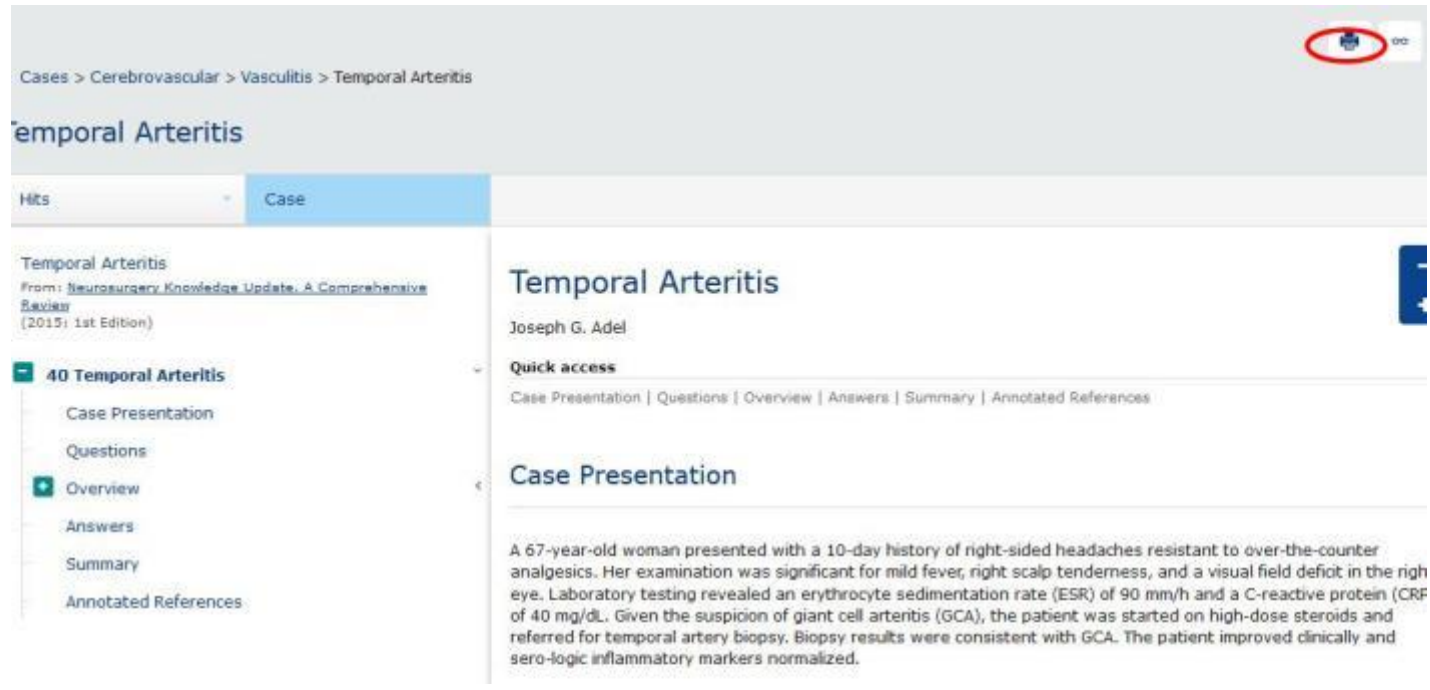

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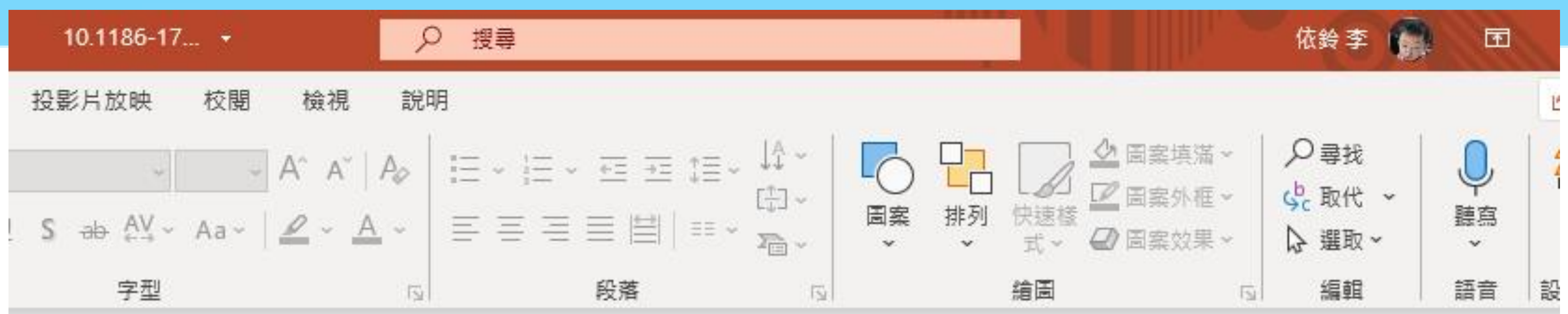

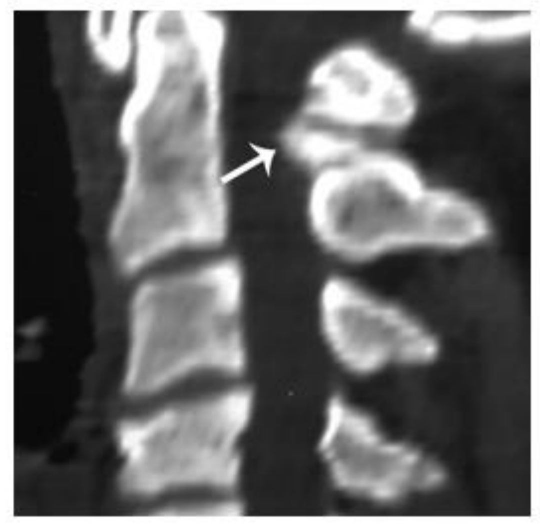

Figure 2 Fig 1 Axial (arrowheads) and Fig 2 sagittal CT demonstrate an expansile lesion (arrow) of the posterior arch of C1. It is contained within the cortex with no soft tissue extension. The bony margins appear smooth, homogeneous and sclerotic.

Source: Elias I, Pahl M, Zoga A, et al. Recurrent burner syndrome due to presumed cervical spine osteoblastoma in a collision sport athlete – a case report. Journal of Brachial Plexus and Peripheral Nerve Injury. 2007; 02(01): 61 - 65 doi:10.1186/1749-7221-2-13

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Color Atlas of Brainstem Surgery

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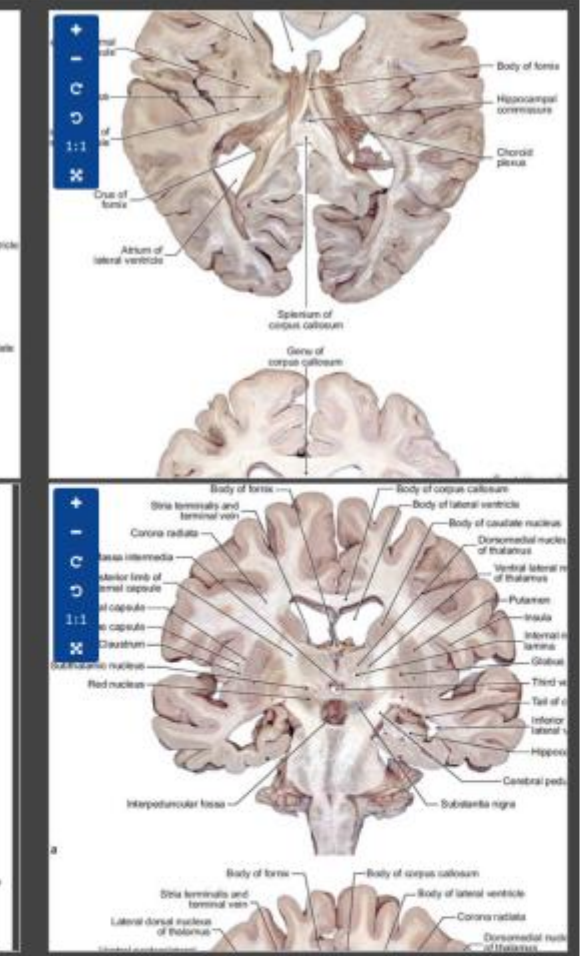

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對於有經驗的專科醫生或住院醫生來說，MedOne是一個易於使用的平台，它結合了專家資訊及多媒體視覺資料，更是一個學習及教學的工具。

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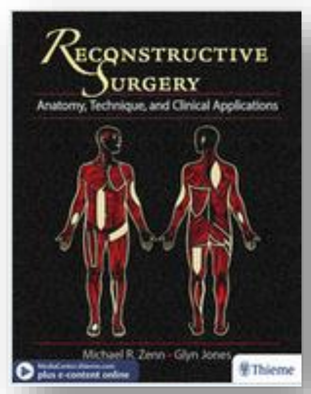
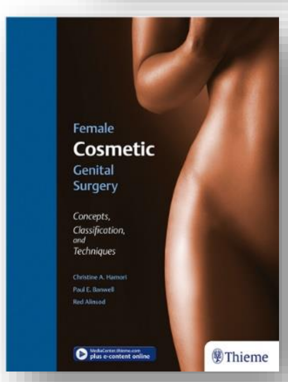
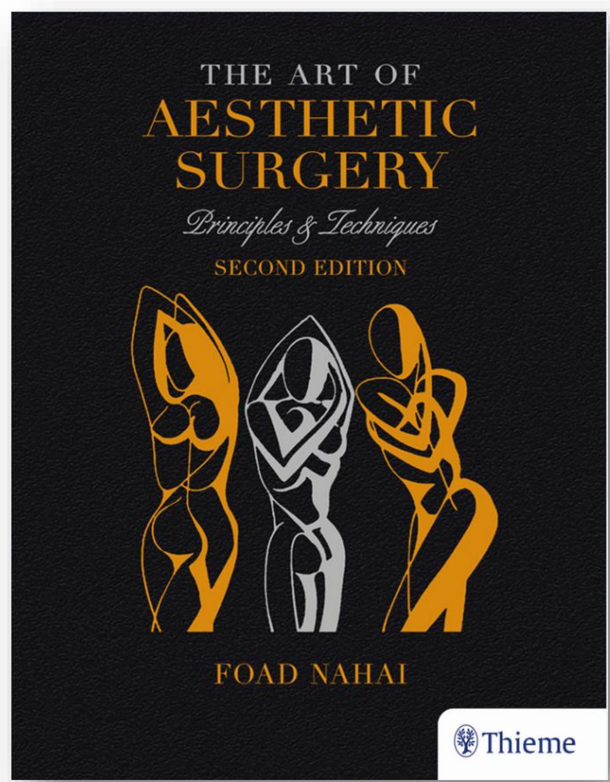
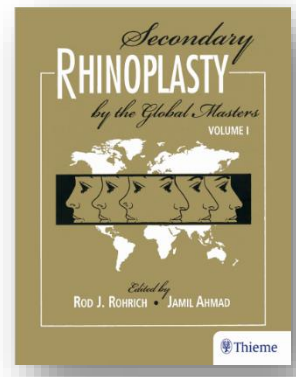
收錄內容-電子書

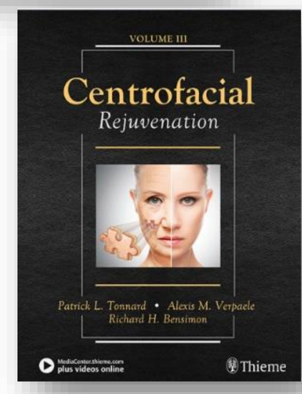
目前收錄超過120種有關整形重建和美容手術的重要電子書。無論你是在攻讀還是學習技術，都可以根據自己的需求使用資料庫內所提供的電子書的內容：展開圖片、觀看視頻、下載章節、個人化筆記、客製化閱讀清單和追蹤文章連結。











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MedOne整形外科的“手術流程”為您準備了進入手術室所需的內容：透過step-by-step的方式讓您可以快速審視一個棘手的手術，或透過觀看不同的手術流程來了解手術的細節並藉由評估是否有其他更好的治療方法。

Hair transplantation

Surgical anatomy | Technique | Complications | Videos

Source: Barrera A, Uebel C, ed. Hair Transplantation: The Art of Follicular Unit Micrografting and Minigrafting. 2nd Edition. Thieme; 2013. doi:10.1055/b-006-160945

Chapter 1 Anatomy and Physiology of Hair
- Types of Hair
- Hair Follicle Development
- Hair Follicle Histology
- Follicular Unit Concept
- Hair Follicle Cycle
- Follicular Stem Cells
- Applied Anatomy: Alopecias Suitable for Hair Restoration Surgery
- Conclusion
- References

Part I Fundamentals > Chapter 1 Anatomy and Physiology of Hair

Anatomy and physiology of hair

Quick access

Types of Hair|Hair Follicle Development|Hair Follicle Histology|Follicular Unit Concept|Hair Follicle Cycle|Follicular Stem Anatomy: Alopecias Suitable for Hair Restoration Surgery|Conclusion|References

Francisco Jiménez, Alfonso Barrera, Carlos Oscar Uebel

Historically, hair has been a source of pride to humans and is a distinguishing feature that adorns as well as

Midface lift

Technique | Complications | Videos

Operative technique
From: The Art of Aesthetic Surgery, Principles & Techniques. (2010; 2nd Edition)

Operative Technique
- Markings and Incisions
- Patient Positioning and Anesthesia
- Upper Lid Blepharoplasty: Exposure of the Lateral Orbital Rim and Temporal Fascia
- Midface Dissection
- Elevation and Fixation
- Excision of Lower Lid Skin
- Volume Replacement
- Brow Repositioning and Neck Lifting as a Component of Midface Rejuvenation
- Skin Resurfacing

PART VII MIDFACIAL REJUVENATION > CHAPTER 37 Midface Recontouring > Operative Technique

Operative technique

Quick access

Markings and Incisions | Patient Positioning and Anesthesia | Upper Lid Blepharoplasty: Exposure of the Lateral Orbital Rim and Temporal Fascia | Midface Dissection | Elevation and Fixation | Excision of Lower Lid Skin | Volume Replacement | Brow Repositioning and Neck Lifting as a Component of Midface Rejuvenation | Skin Resurfacing

Markings and Incisions

Subciliary lower lid incision with lateral extension in a preexisting skin crease

收錄內容-向專家學習

這些專家開創了您使用的技術和您尚未使用的尖端手術。當您在進行或學習他們擅長的手術時，為什麼不向大師學習呢？來自全球43名整形外科知名專家的資料包括視頻，解釋他們的技術、演示操作和討論併發症，因此您不需要周遊世界，就可以在您的導師中找到最好的。

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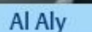

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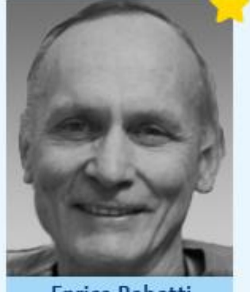
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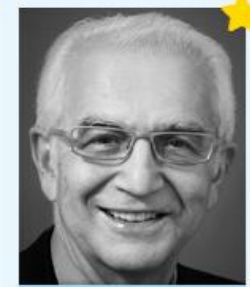
Foad Nahai

Fu Chan Wei: Master videos

Profile & videos

Source: Fu-Chan Wei. In: Plastic Surgery: Masters Profiles. 1st Edition. Thieme; 2020.

Fu-Chan Wei

Fu Chan Wei – Personal profile and master videos

Quick access

Personal profile|Master videos

Personal profile

Fu-Chan Wei, MD

Fu-Chan Wei, MD is a world-renowned plastic and reconstructive surgeon, and one of the most influential and innovative surgeons in the history of plastic surgery. The Taiwanese legend is the innovator of the osteoseptocutaneous fibula flap, which revolutionized the reconstruction of composite bone and soft tissue defects in the jaw and extremities. He has

收錄內容-多媒體資料

在整形手術中，進行過程與結果都很重要。這就是為什麼平臺的圖像清楚地呈現了方法和結果。

在多媒體頁面可方便地展開、下載或比較圖像，亦可透過資源外部連結瞭解更多資訊。

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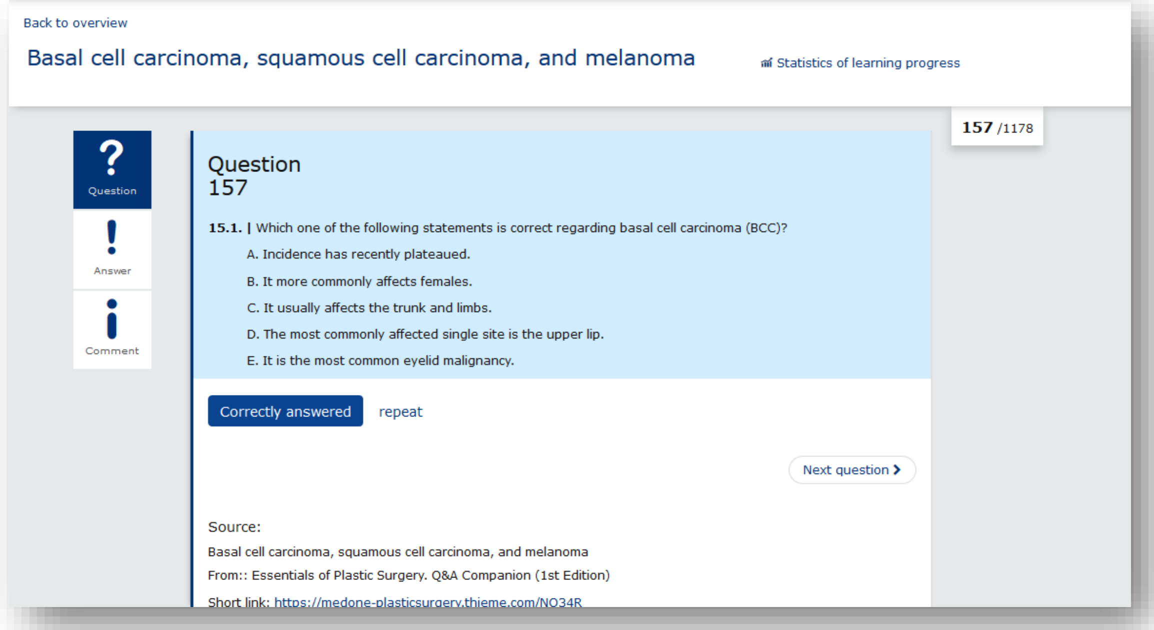

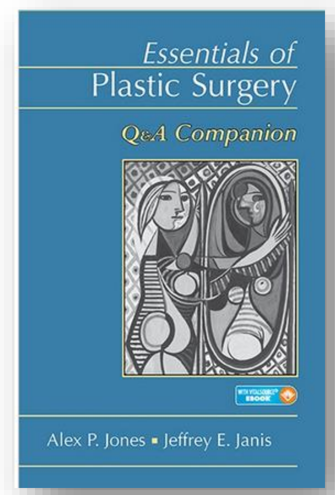

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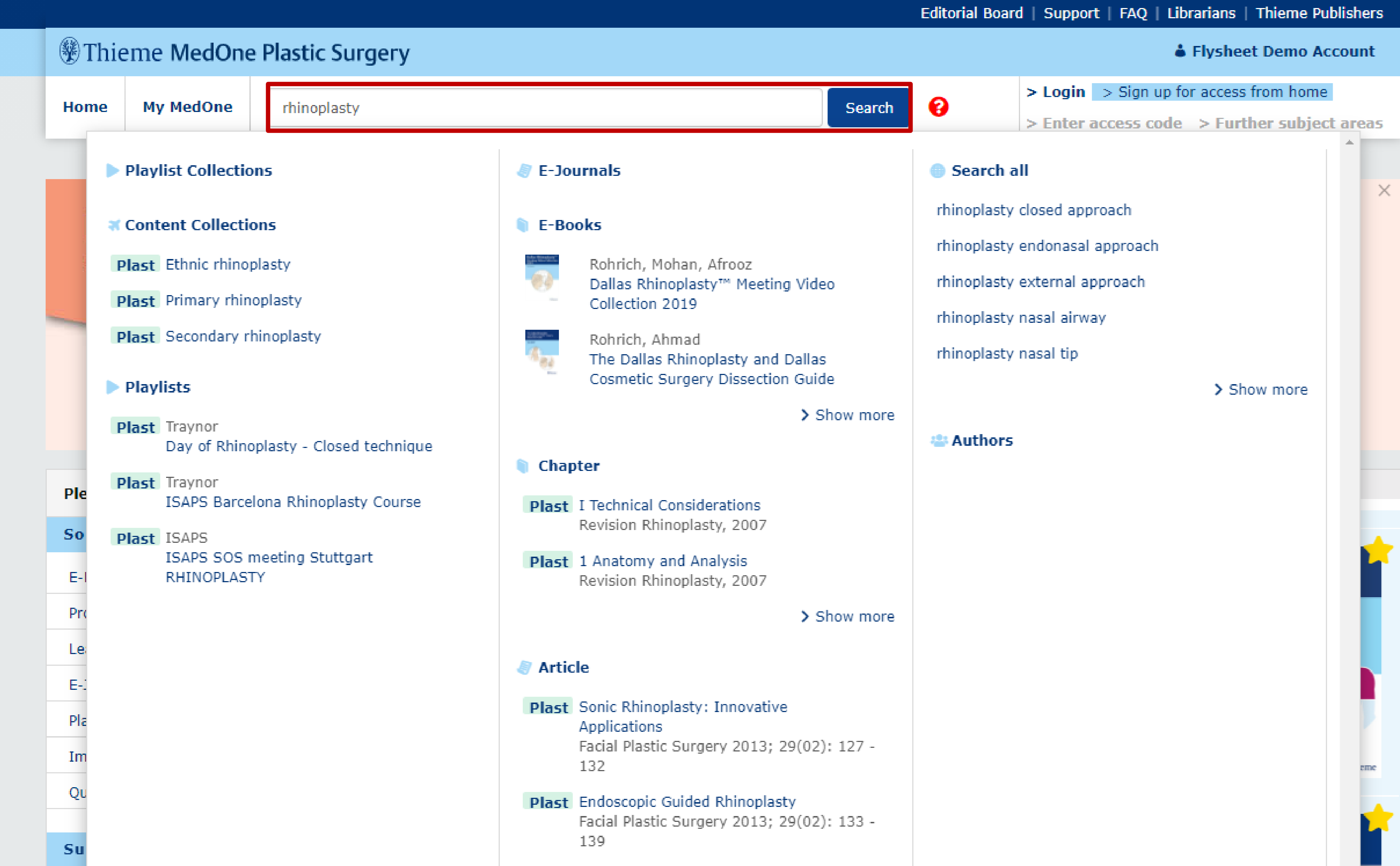

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Authors: S. Douglas Steinbrech

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63 5 3 Elevation of the Skin Flap for an External **Rhinoplasty** Approach The Art of Aesthetic Surgery Principles Techniques Part X **Rhinoplasty** 63 Asian **Rhinoplasty** 63 5 Operative Technique 63 5 3 Elevation of the Skin Flap for an External... ... **Rhinoplasty** Approach 63 5 3 Elevation of the Skin Flap...

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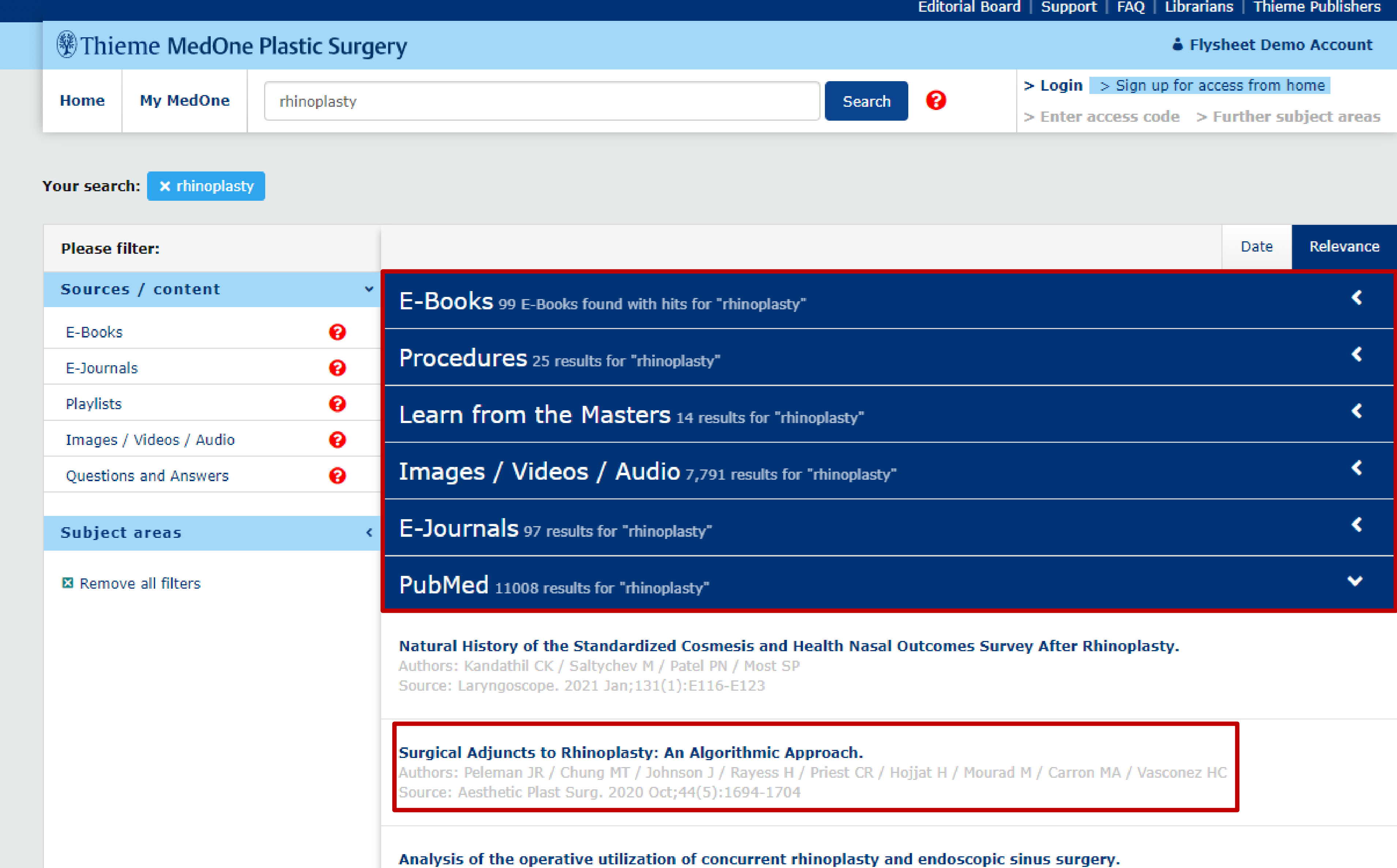

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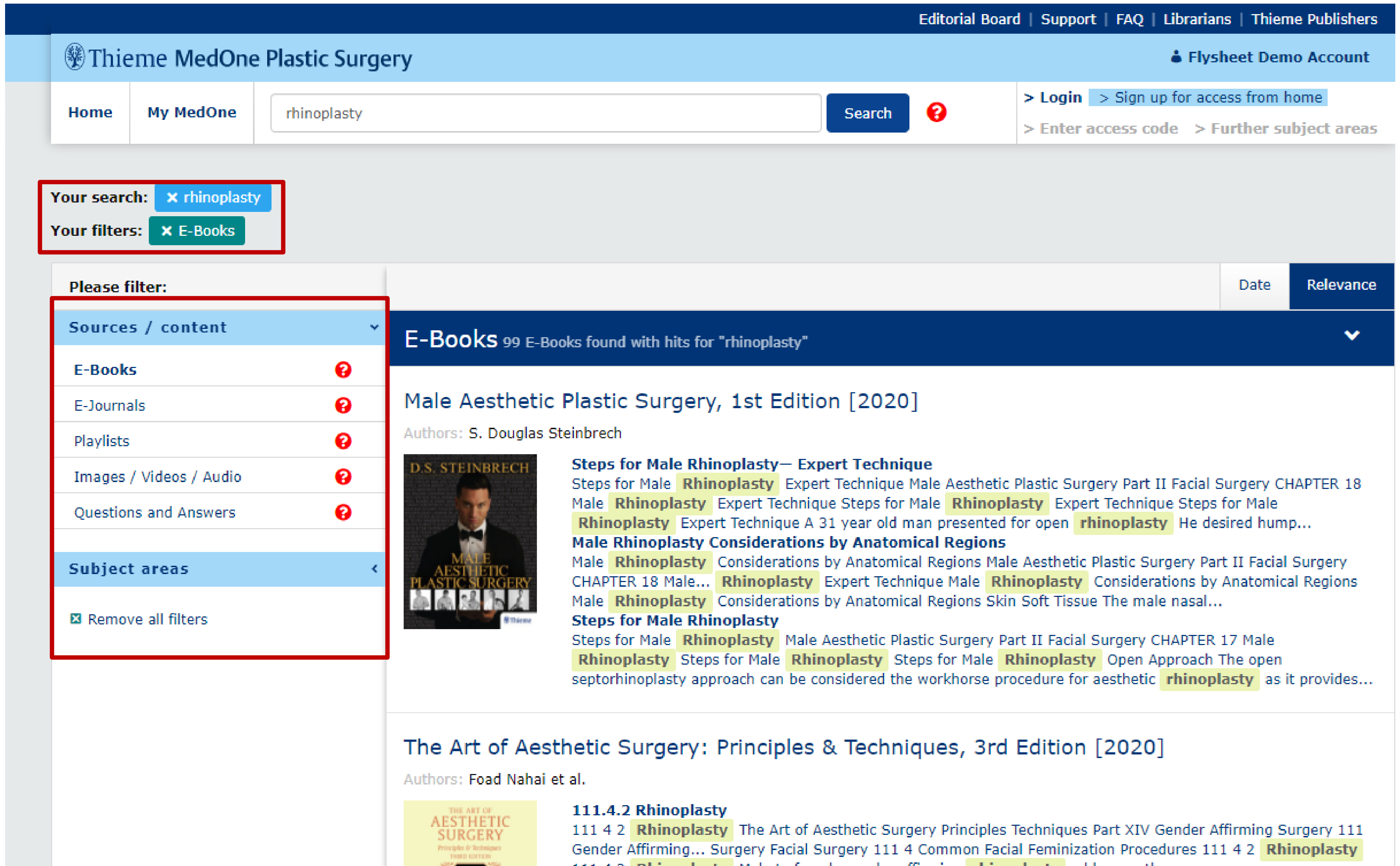

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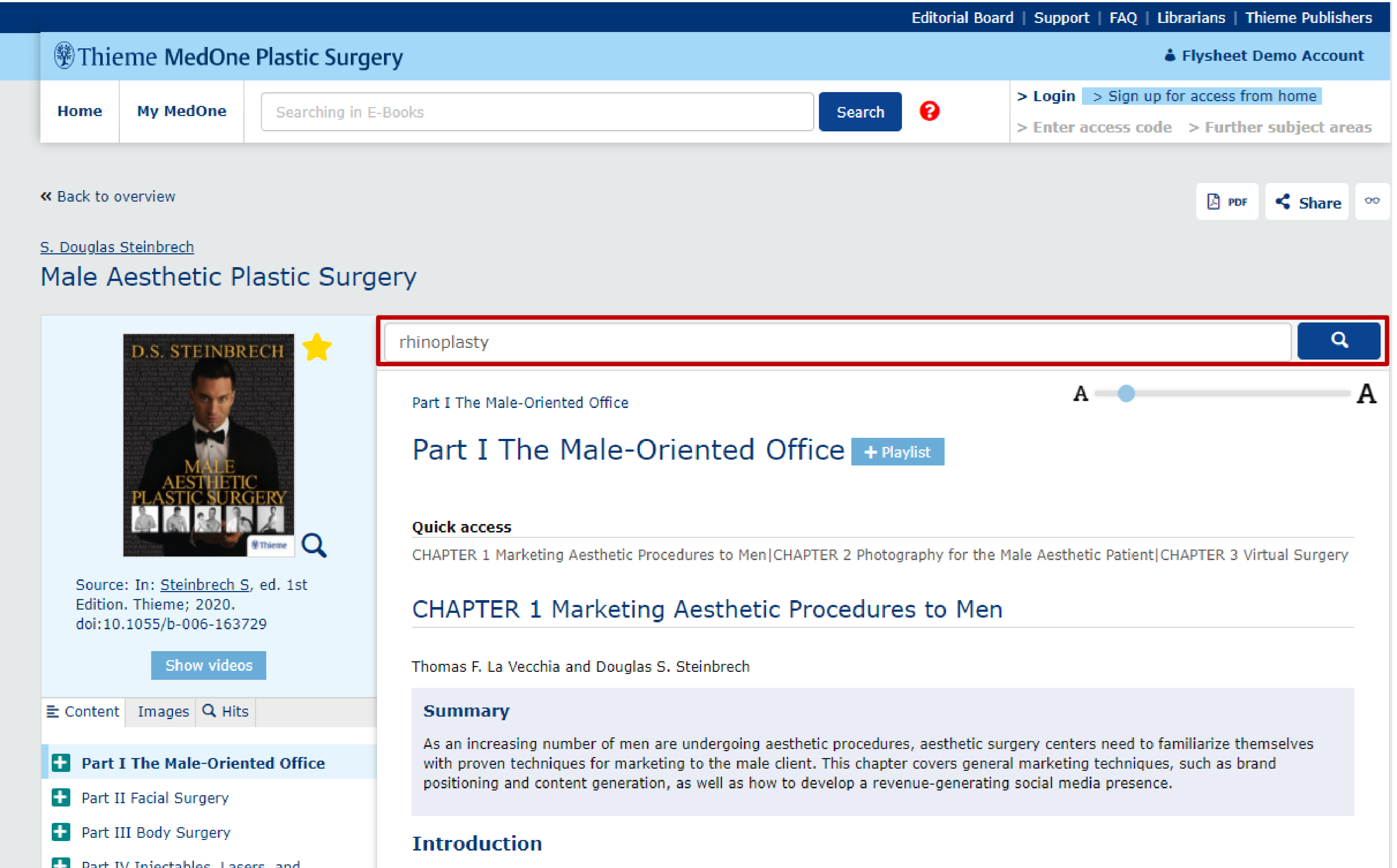

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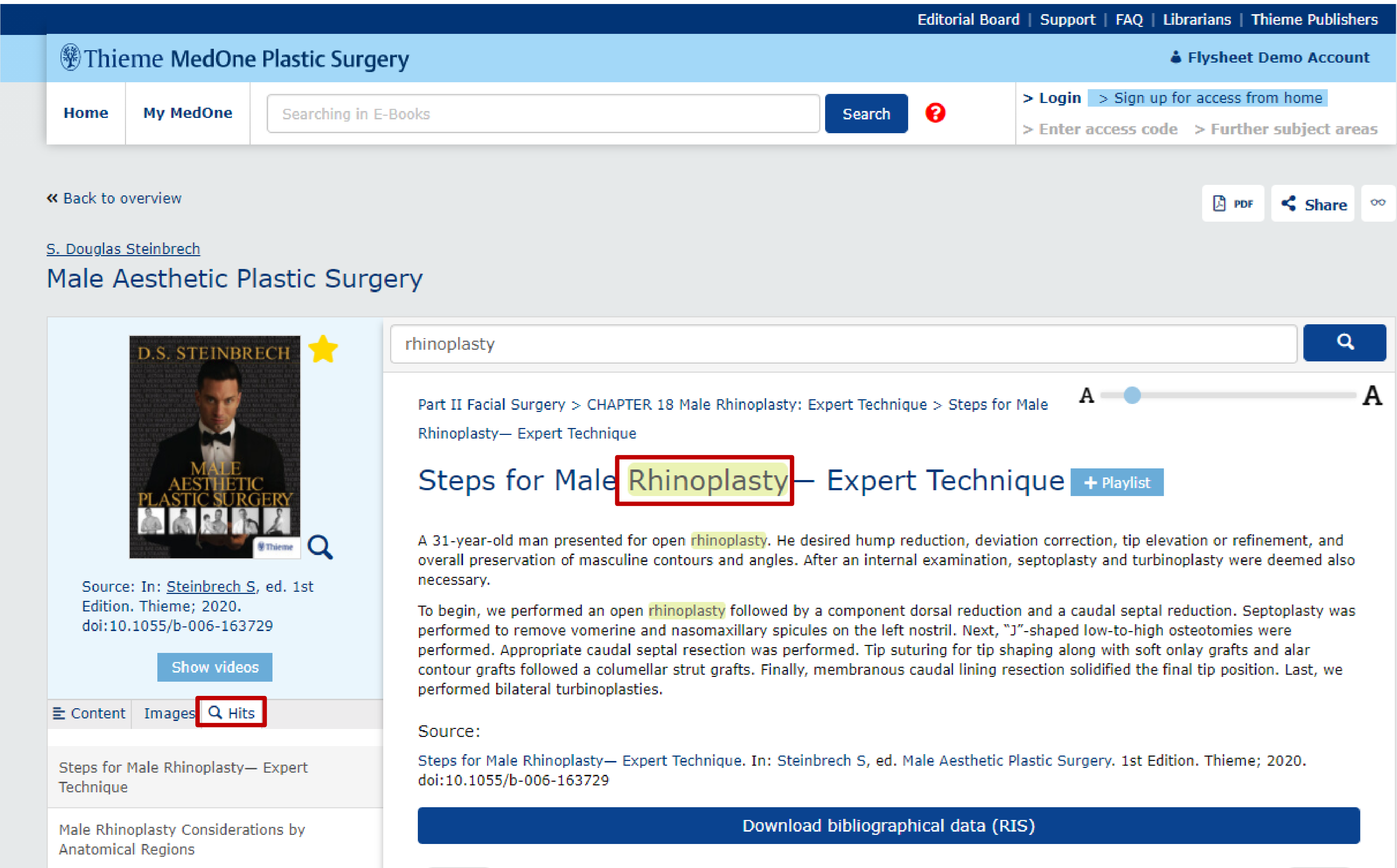

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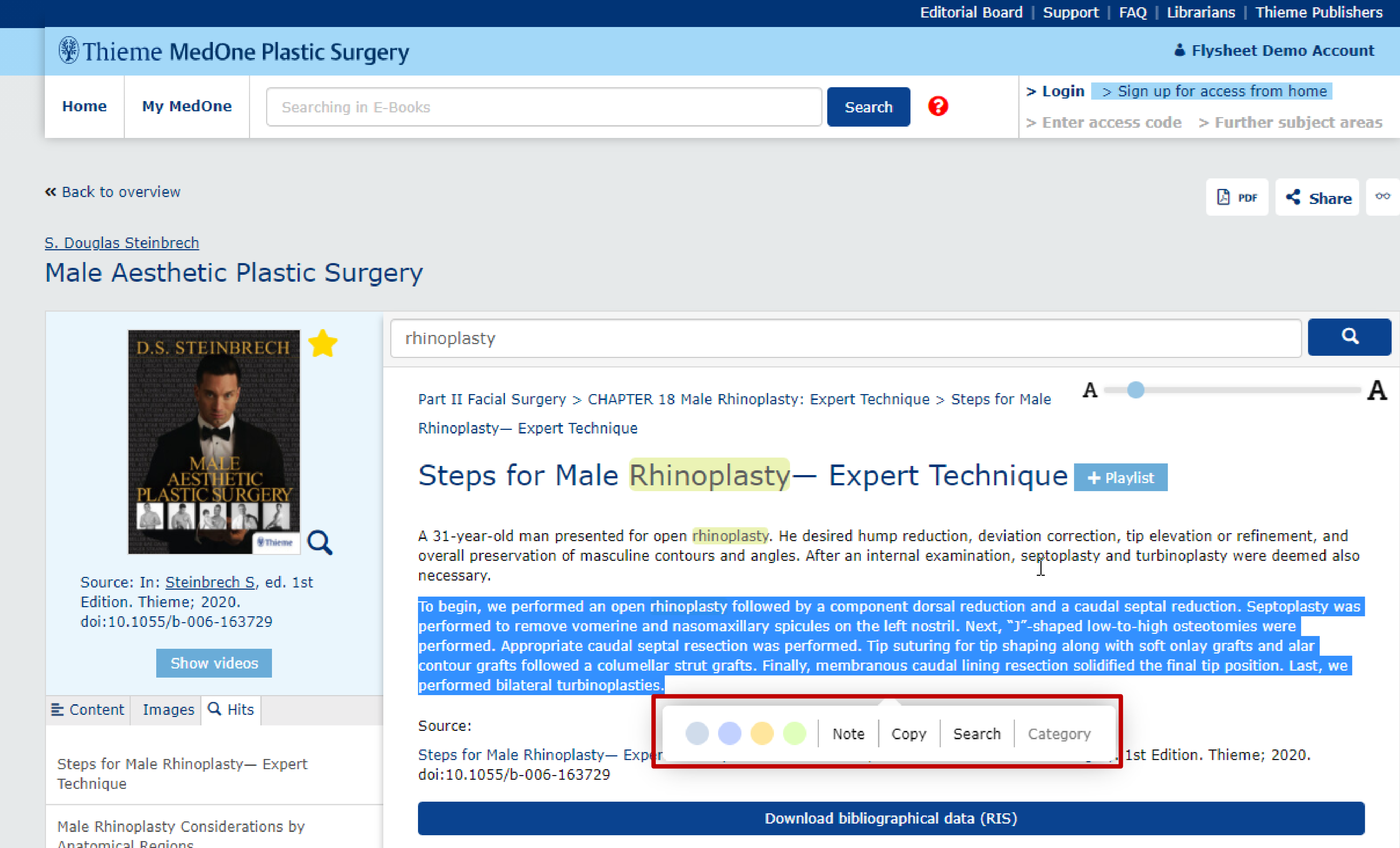

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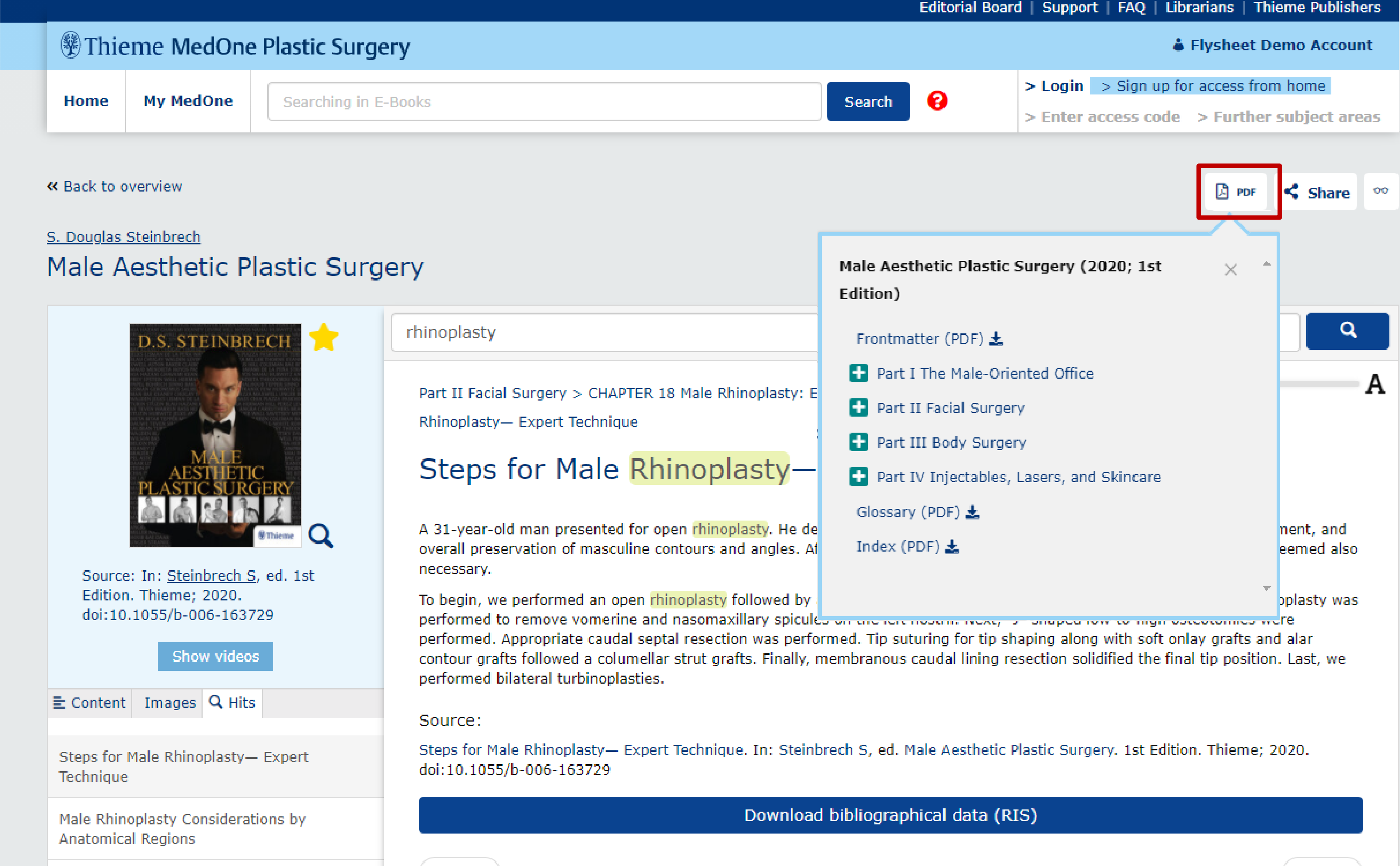

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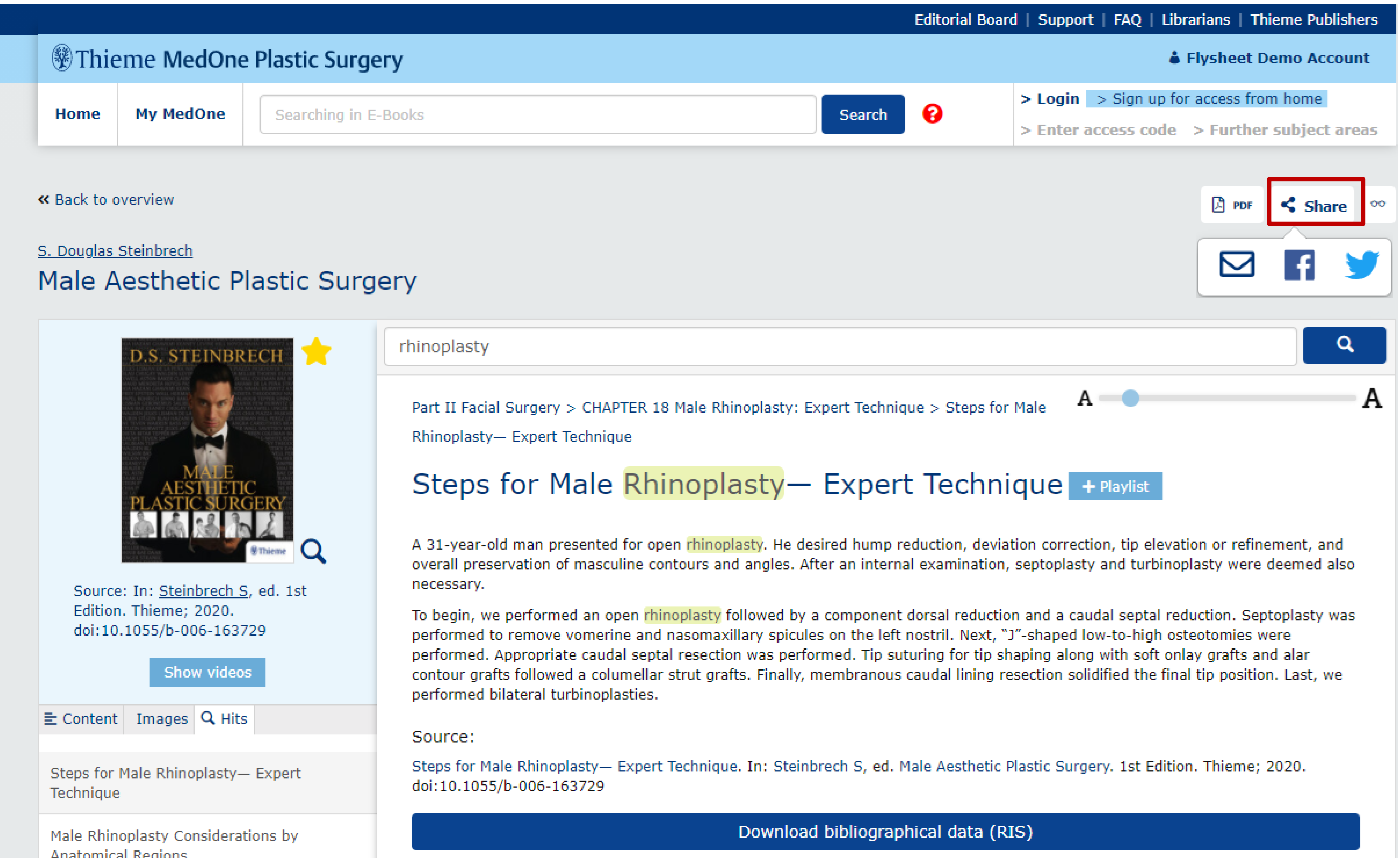

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S. Douglas Steinbrech

Male Aesthetic Plastic Surgery

Part II Facial Surgery > CHAPTER 4 Techniques for Forehead Rejuvenation

Part II Facial Surgery

CHAPTER 4 Techniques for Forehead Rejuvenation

Ximena Pinell and Foad Nahai

Evaluation of the Aging Forehead and Brow|Goals of Forehead Rejuvenation|Options for Forehead Rejuvenation|Coronal Brow Lift|Endoscopic Brow Lift|Lateral Temporal Brow Lift|Transpalpebral Corrugator and Procerus Excision|Transpalpebral Browpexy|Direct Excision|Neurotoxins|Bulleted Steps|Suggested Readings

Summary

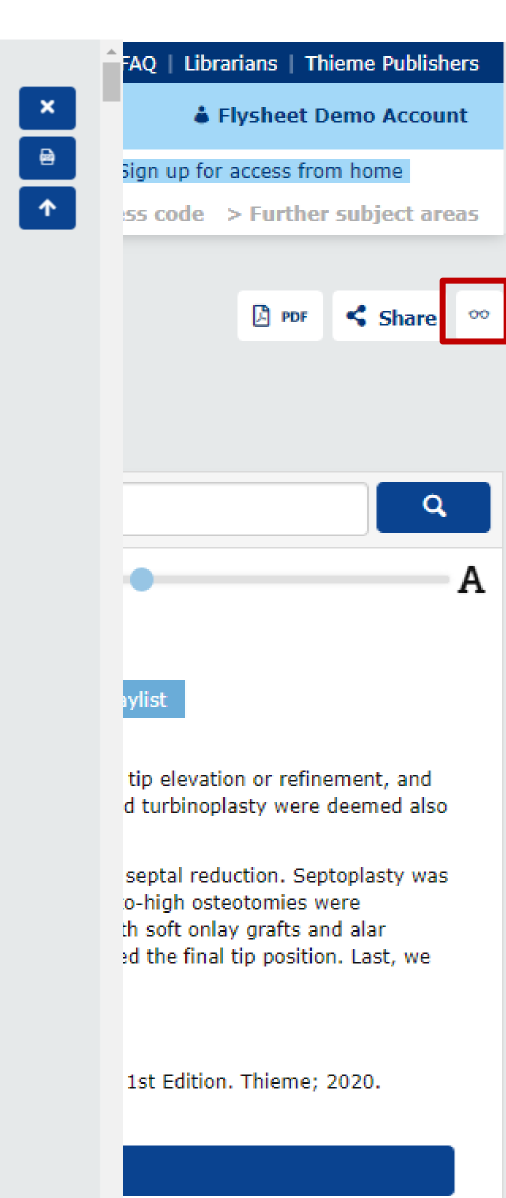
Aging in the upper face can create a tired, unhappy, or even angry appearance. Surgical procedures to rejuvenate the forehead and brow can be very impactful to a person's overall expression and are thus very rewarding for the patient and surgeon alike. This chapter reviews important features to consider when assessing the aging brow and highlights key differences encountered in the male patient. Various surgical options are presented. Advantages and drawbacks for each approach are described, as are technical points to executing the surgery.

Evaluation of the Aging Forehead and Brow

Facial rejuvenation requires a comprehensive approach to the structures of the face and their interactions. No one feature or area should be considered in isolation, even if patients present with a single area of concern. The contribution of brow ptosis to an aged facial appearance is frequently overlooked but must be considered to achieve a natural, balanced, and aesthetic result.

In evaluating the aging forehead and brow, important features to consider are as follows:

- Brow position and shape.
- Orbital crowding.



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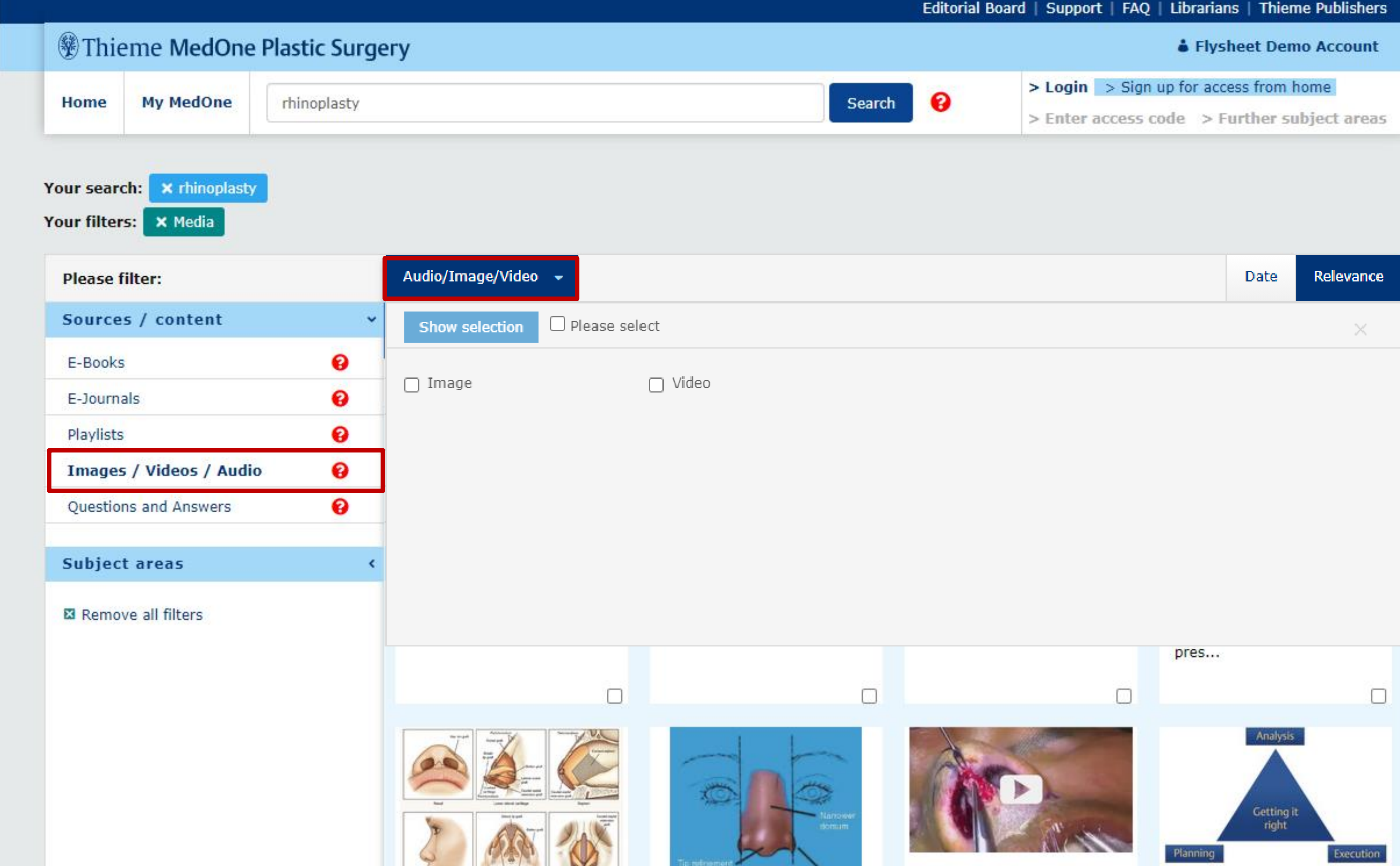

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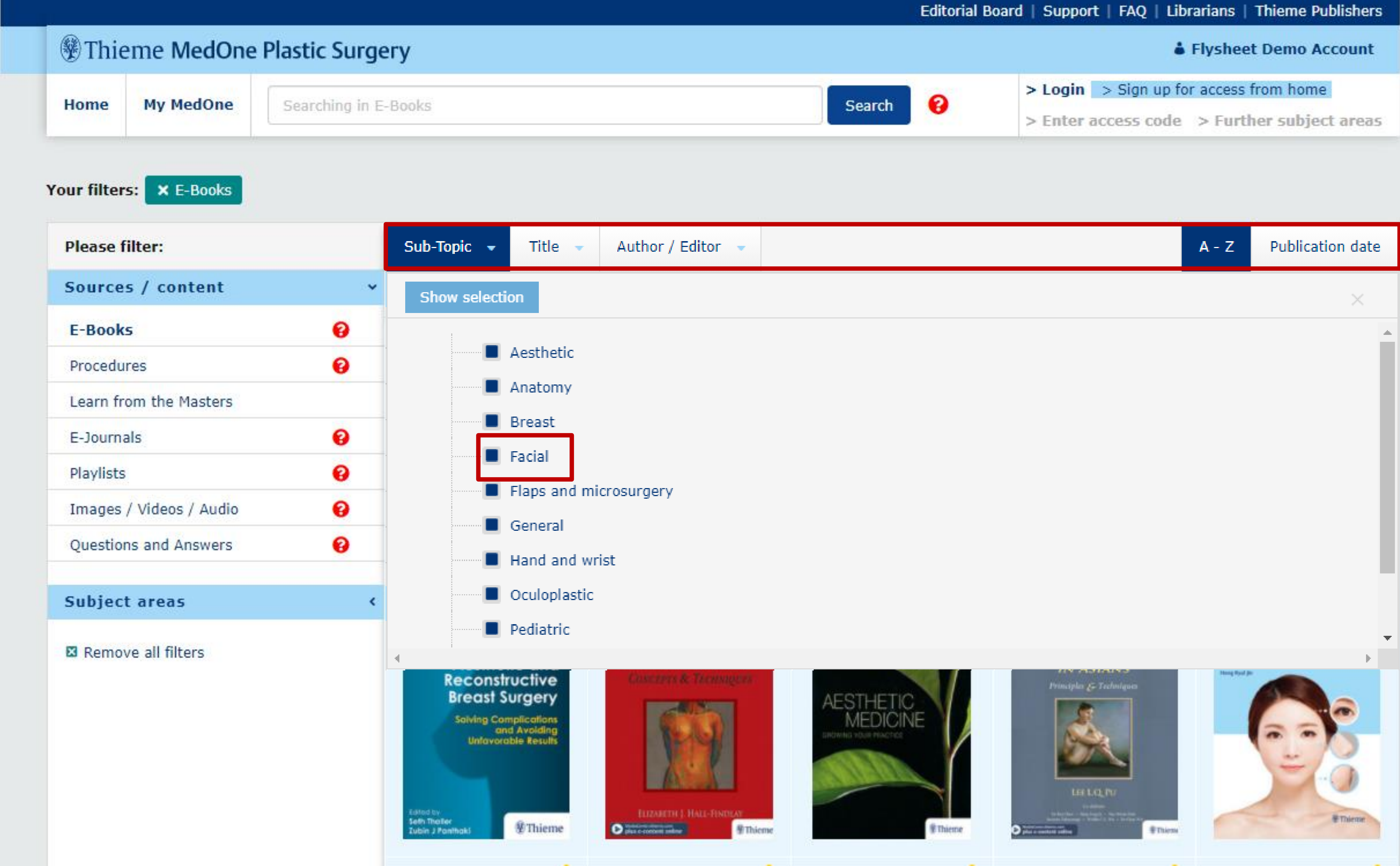

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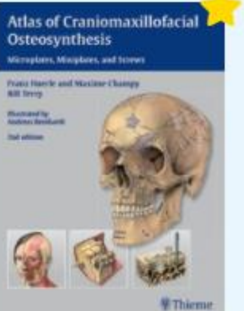

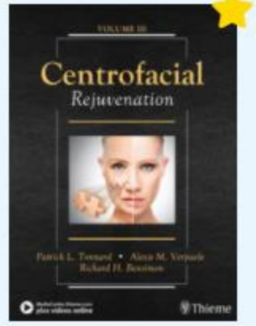

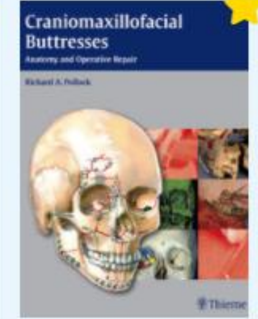

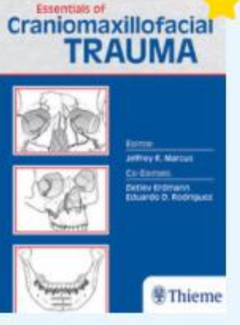

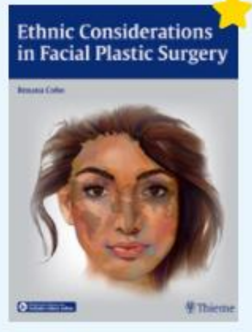

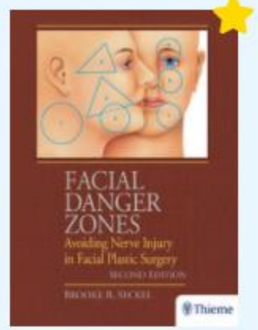

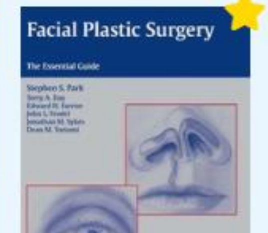

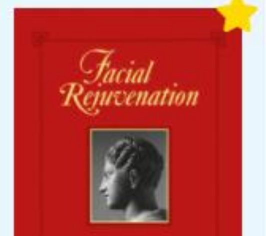

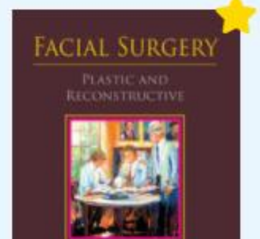

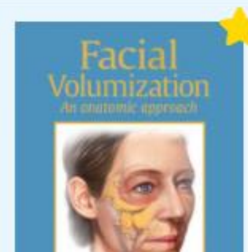

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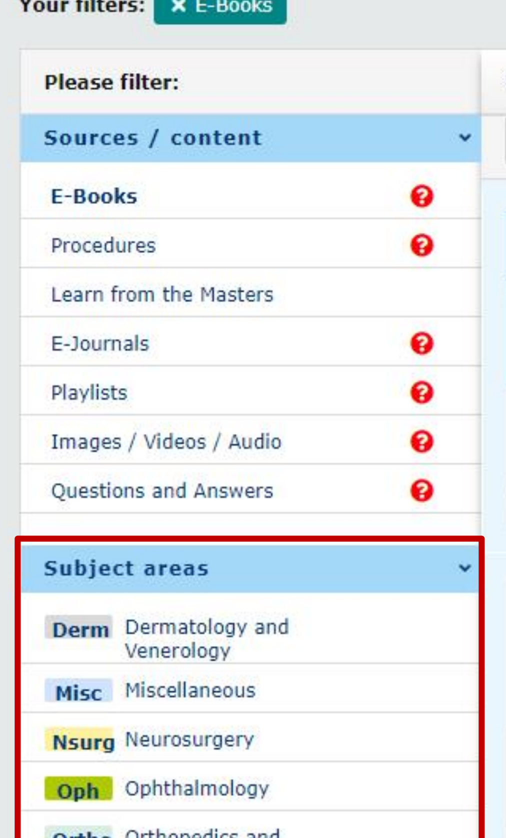

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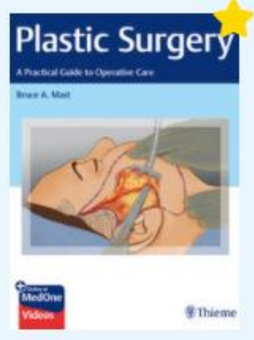

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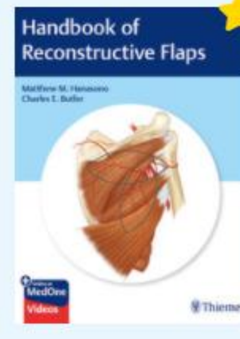

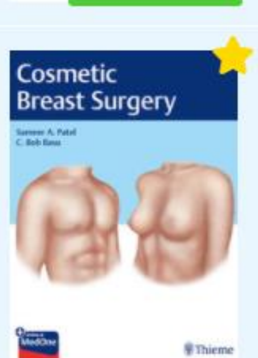

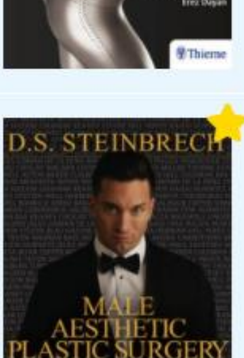

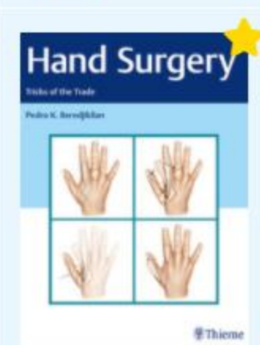

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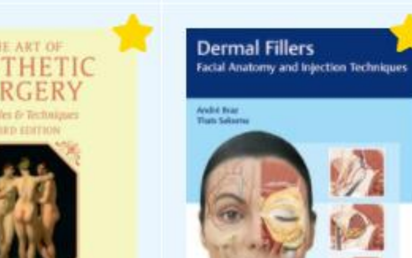

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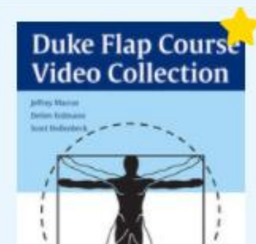

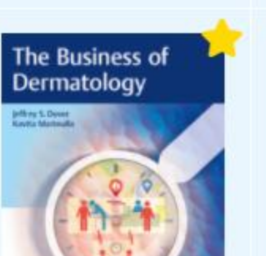

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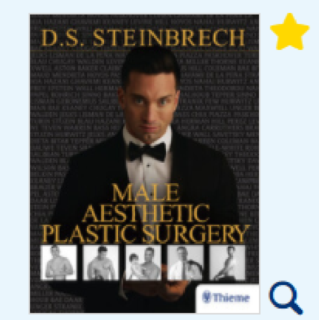
Male Aesthetic Plastic Surgery



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CHAPTER 1 Marketing Aesthetic Procedures to Men

Thomas F. La Vecchia and Douglas S. Steinbrech

Summary

As an increasing number of men are undergoing aesthetic procedures, aesthetic surgery centers need to familiarize themselves with proven techniques for marketing to the male client. This chapter covers general marketing techniques, such as brand positioning and content generation, as well as how to develop a revenue-generating social media presence.

Introduction

X Factor Media was approached by Dr. Douglas S. Steinbrech in late 2013 with a new initiative. He wanted to roll out a website dedicated to male aesthetic surgery. At the time, we were a bit skeptical. Our research showed that men only constituted for roughly 9% of all aesthetic procedures in 2012. We were tasked with creating a website or an online resource (more or less). Male Plastic Surgery New York was born (www.MalePlasticSurgeryNewYork.com) (**Fig. 1.1**).

Our Approach: Build the Platform

X Factor Media started the campaign with reviewing the top procedures for men. According to the American Society for Aesthetic Plastic Surgery (ASAPS),[1] they are:

- Liposuction.
- Gynecomastia (removal of breast tissue).
- Eyelid surgery.
- Rhinoplasty.
- Facelift.

S. Douglas Steinbrech

Male Aesthetic Plastic Surgery

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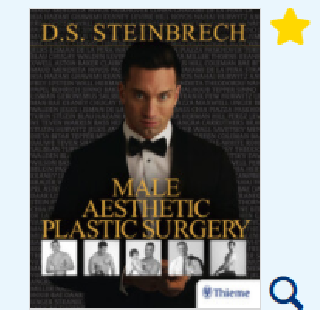
Male Aesthetic Plastic Surgery 2020; 1st Edition

Fig. 1-3. Infographic featured on maleplasticsurgerynewyork. com that was eventually picked up by numerous media outlets. (This image is provided courtesy of Male Plastic Surgery New York.)

S. Douglas Steinbrech

Male Aesthetic Plastic Surgery



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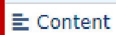

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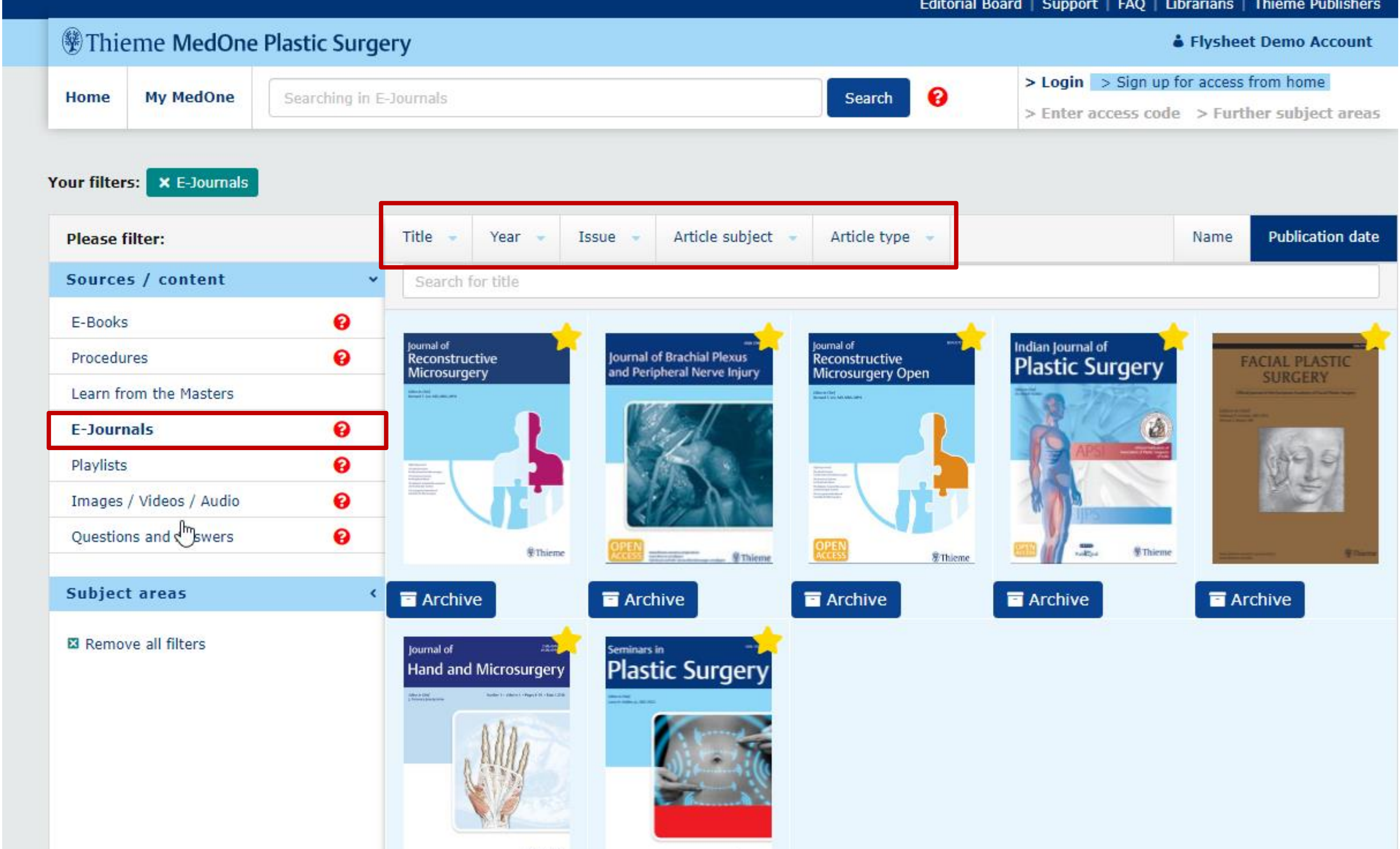

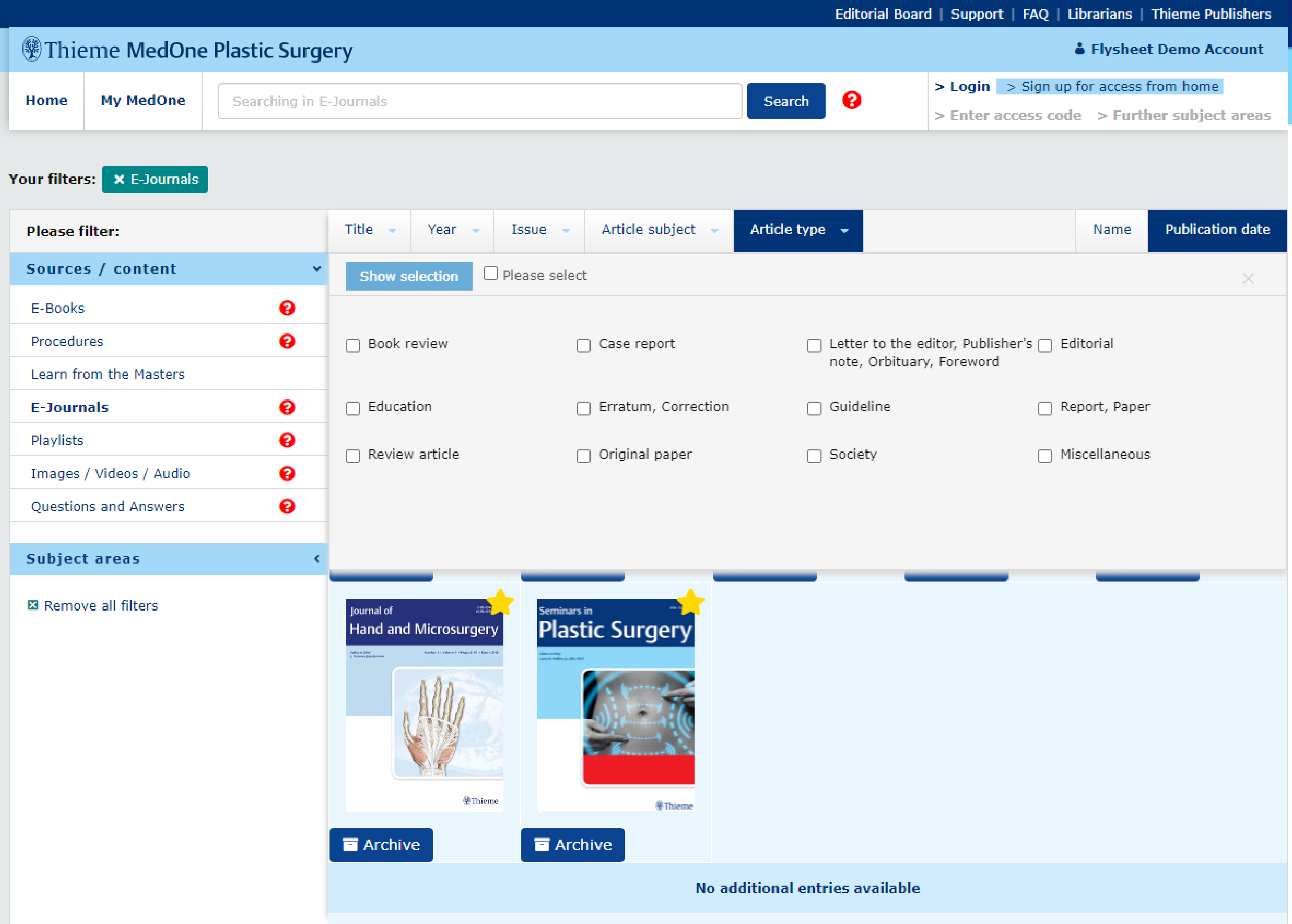
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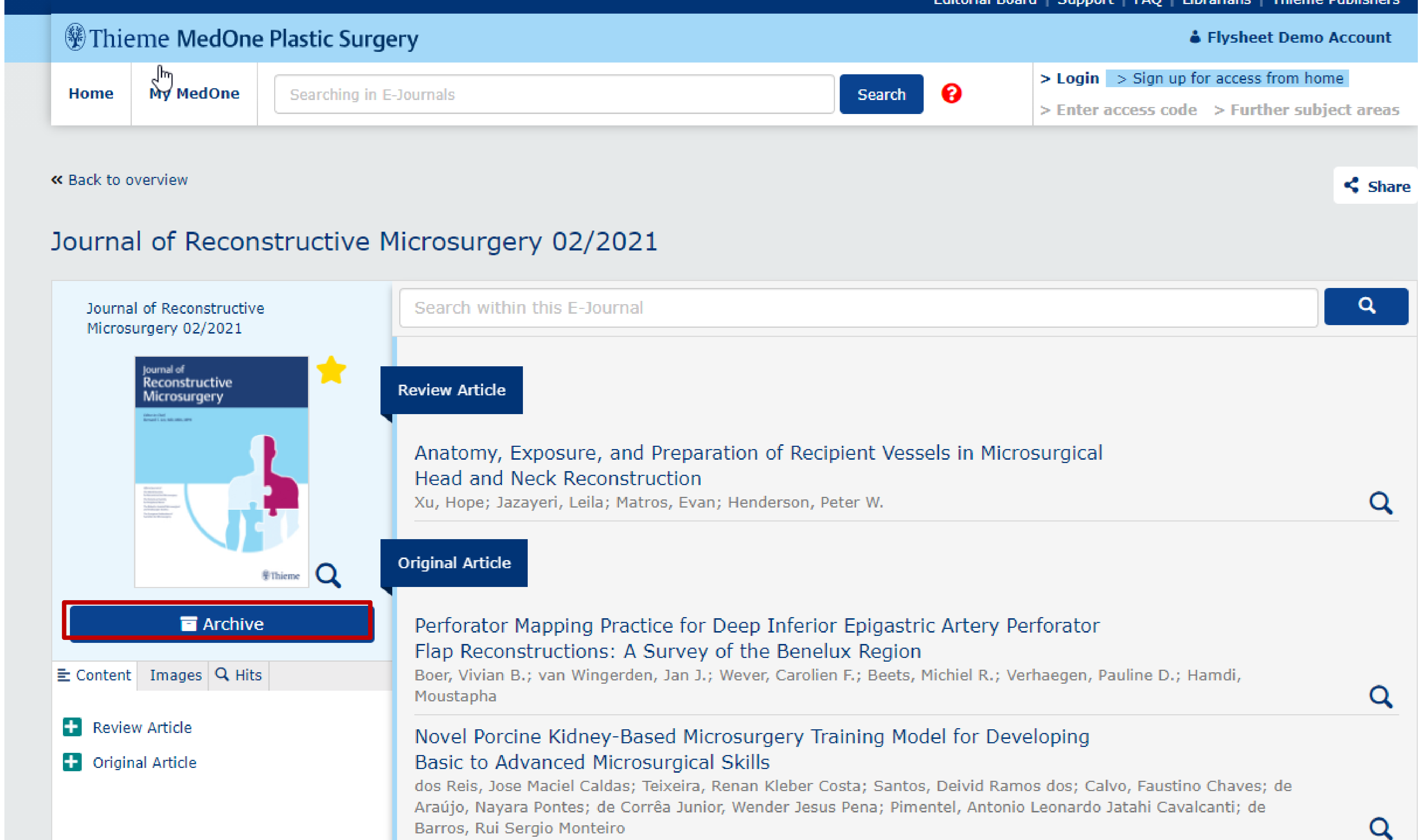

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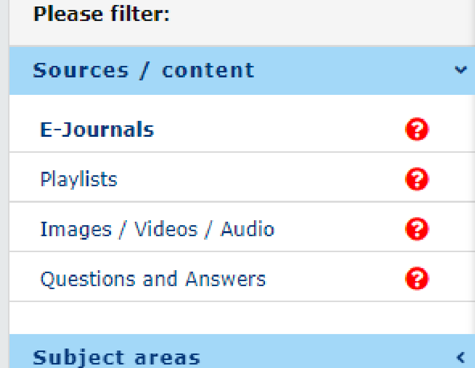

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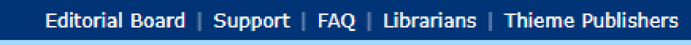
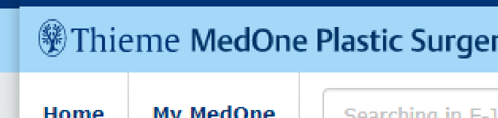

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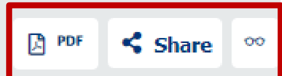

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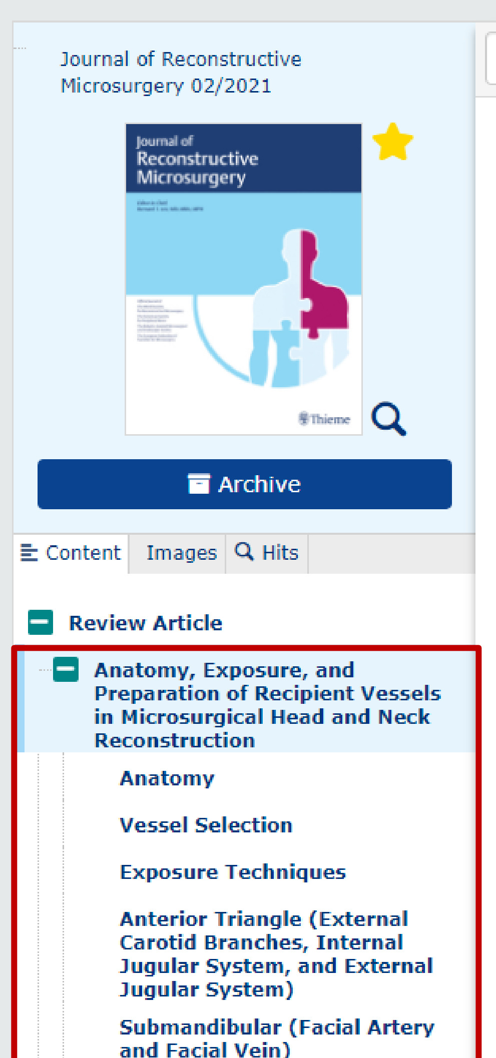

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Review Article

Xu, Hope[1]; Jazayeri, Leila[2]; Matros, Evan[3]; Henderson, Peter W.[1]

Anatomy, Exposure, and Preparation of Recipient Vessels in Microsurgical Head and Neck Reconstruction

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[1] Division of Plastic and Reconstructive Surgery, Department of Surgery, Icahn School of Medicine at Mount Sinai, New York, New York
[2] Department of Plastic Surgery, Kaiser Permanente, San Leandro Medical Center, San Leandro, California
[3] Plastic and Reconstructive Surgical Service, Memorial Sloan Kettering Cancer Center, New York, New York

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Anatomy|Vessel Selection|Exposure Techniques|Anterior Triangle (External Carotid Branches, Internal Jugular System, and External Jugular System)|Submandibular (Facial Artery and Facial Vein)|Intraoral (Facial Artery and Facial Vein)|Posterior Triangle (Transverse Cervical Artery and Transverse Cervical Vein)|Preauricular (Superficial Temporal Artery and Superficial Temporal Vein)|Chest (Internal Mammary Artery and Internal Mammary Vein[s])|Arm/Infraclavicular Region (Cephalic Vein)|Conclusion|References

Abstract

Successful microvascular reconstruction of head and neck defects requires the ability to safely identify, isolate, and utilize recipient vessels. To date, however, a comprehensive review of the anatomy and techniques relevant to the available anatomic regions has not been undertaken. This review covers the relevant clinical anatomy of the anterior triangle, posterior triangle, submandibular region, intraoral region, preauricular region, chest, and arm, taking particular care to highlight the structures that are crucial to identify while performing each dissection. Finally, a step-by-step technique for safely dissecting the recipient

8 Yu P. The transverse cervical vessels as recipient vessels for previously treated head and neck cancer patients. Plast Reconstr Surg 2005; 115 (05) 1253-1258

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9 Venkatesh V, Fracol M, Turin S, Ellis M, Alghoul M. Utilization of intraparotid segments of superficial temporal vessels for head and scalp free flap microanastomosis: a clinical, histological, and cadaveric study. J Reconstr Microsurg 2020; 36 (04) 253-260

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10 Shankhdhar VK, Yadav PS, Dushyant J, Seetharaman SS, Chinmay W. Cephalic vein: saviour in the microsurgical reconstruction of breast and head and neck cancers. Indian J Plast Surg 2012; 45 (03) 485-493

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11 Agostini T, Agostini V. Cephalic vein transposition in head and neck microsurgery: advantages of a modified step-wise (closed) technique. J Plast Reconstr Aesthet Surg 2009; 62 (05) 625

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Keywords

head and neck reconstruction – microsurgery – recipient vessels

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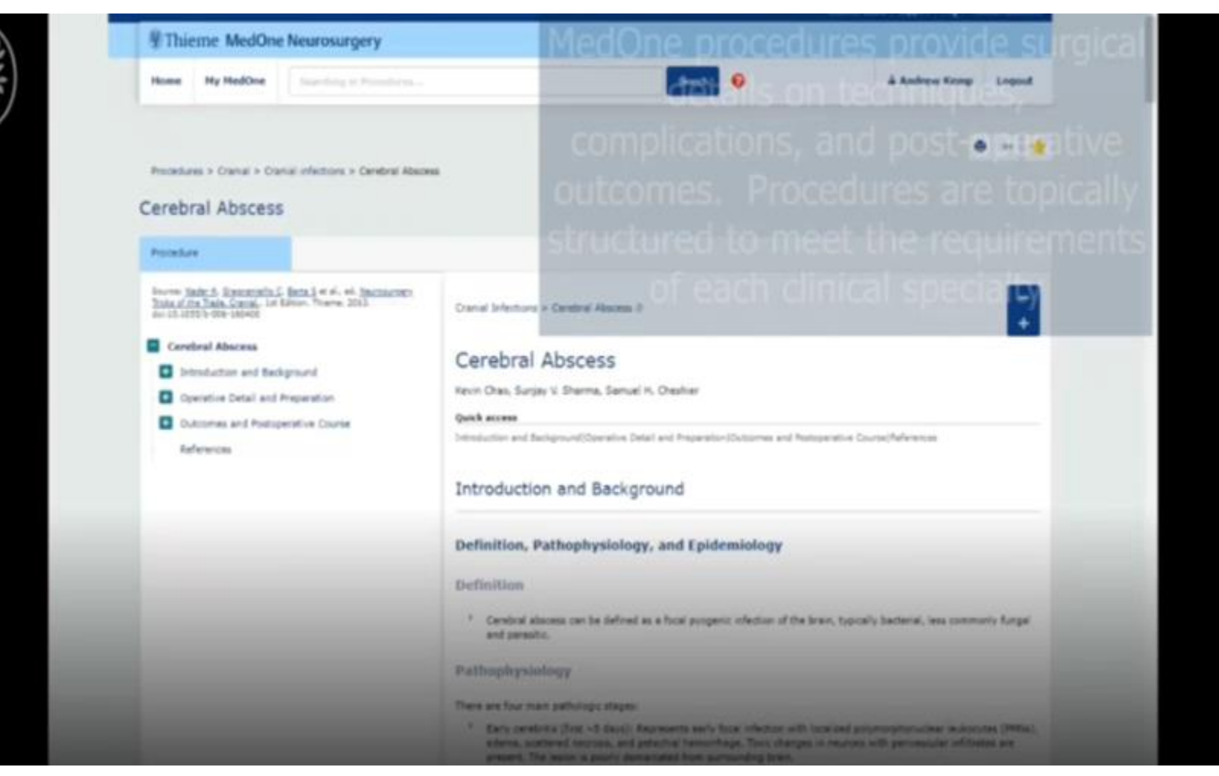

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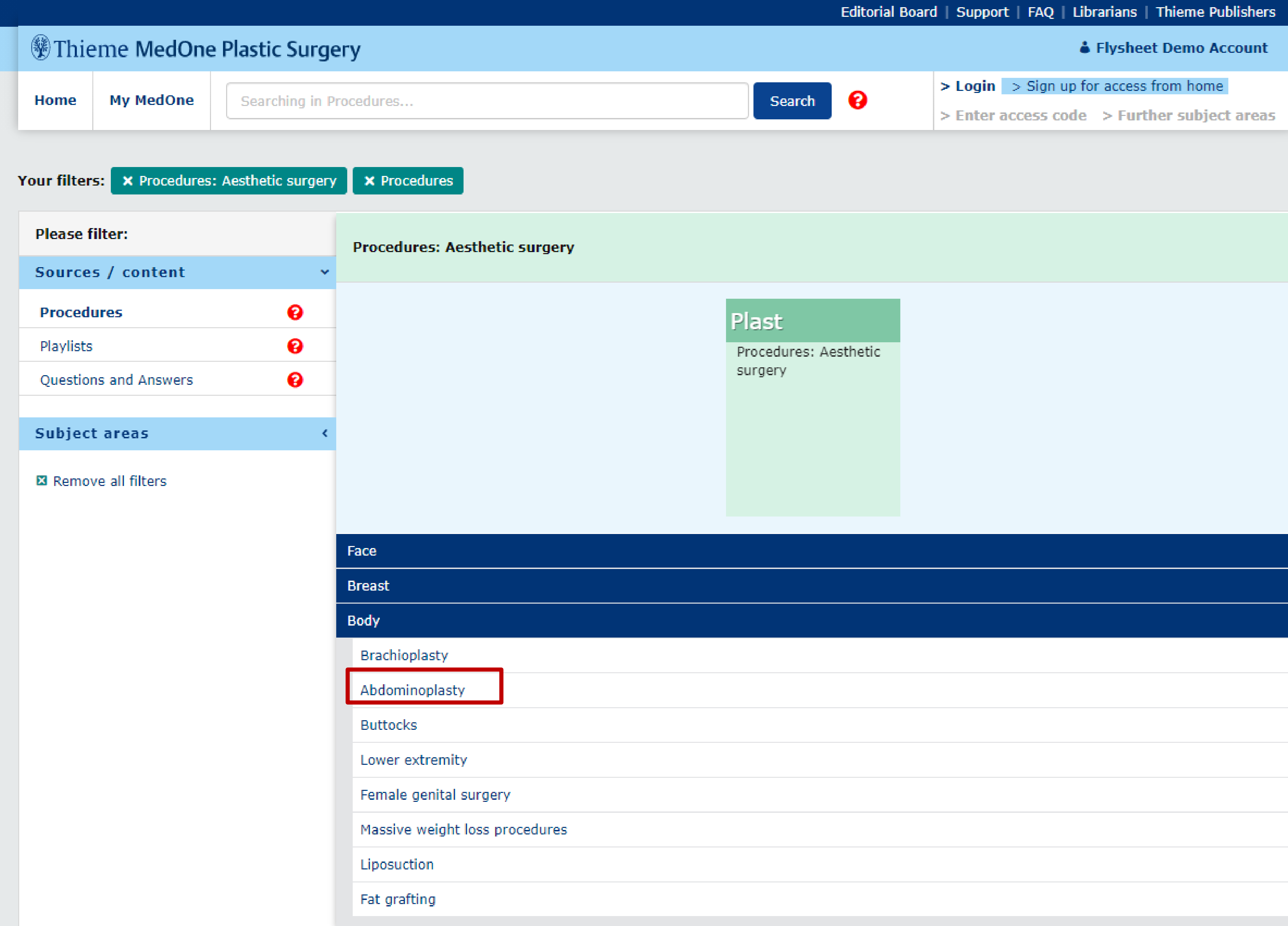

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- SENSITIVE INNERVATION
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- MYOAPONEUROTIC ANATOMY
- THE UMBILICUS

A A

Surgical anatomy

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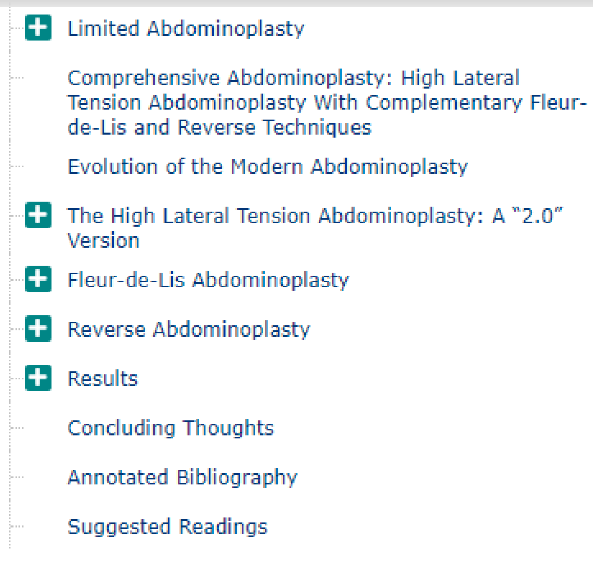
LANDMARKS AND ANATOMIC UNITS OF THE ABDOMEN

Anatomic units are areas that must be respected during abdominoplasty. The anatomic units of the abdomen are the areas limited by natural skin depressions and folds. On the limits of these areas, there are attachments, depressions, bone projections, and anatomic structures that should be preserved and highlighted during surgery. These landmarks serve as guidelines to orient the surgeon in creating aesthetic contours, or restoring these details in patients who once had them.

Abdominoplasty



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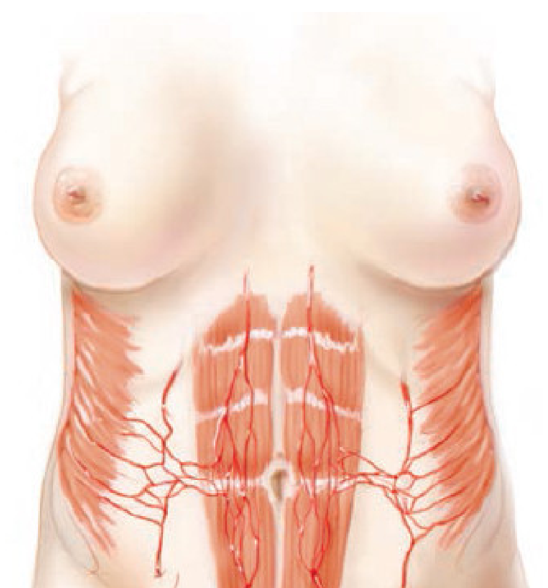

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- Avoiding Unfavorable Results and Complications in Abdominoplasty
  - Primary Goals
    - Removal of Excess Soft Tissue
    - Correction of the Rectus Diastasis
  - Secondary Goals
    - Scar Placement and Quality
    - Umbilicus
- Managing Unfavorable Results and Complications in Abdominoplasty
  - Seroma and Pseudobursa
  - Cellulitis and Deeper Infection
  - Flap Viability: Ischemia and Necrosis
  - Bleeding and Clotting
  - Patient Satisfaction
- Conclusion
- References

A A

Avoiding unfavorable results

Joseph P. Hunstad and Daniel J. Krochmal

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Avoiding Unfavorable Results and Complications in Abdominoplasty|Managing Unfavorable Results and Complications in Abdominoplasty|Conclusion|References

The primary aims of abdominoplasty are restoration of a more ideal abdominal wall contour and removal of excess abdominal skin and soft tissue. Laudable goals of this procedure are to obtain an abdomen that is thin, tight, and flat. If a surgeon accomplishes these objectives, while achieving a relatively inconspicuous scar, an aesthetically pleasing umbilicus, and a complication-free recovery, a patient is usually quite satisfied with the overall result. If any of these goals are not obtained, the result may be unfavorable.

The "unfavorable" aesthetic results in abdominoplasty are usually correctable with revision procedures. With regard to actual complications, the more common ones are typically minor in nature and management is straightforward. The possible severe complications, including fatal pulmonary embolus, necrosis of the abdominal wall skin and soft tissues, and life-threatening infection, are rare.[1] This chapter presents prevention concepts for the more common complications and the unusual challenging complications, along with their management. Also discussed are some tips and tricks that have resulted in enhanced outcomes in our hands.

Avoiding Unfavorable Results and Complications in Abdominoplasty

The ideal patient for an abdominoplasty is an otherwise healthy, nonsmoking patient with a normal body mass index, a lax abdominal wall with rectus diastasis, and excess abdominal skin. Patients that are at higher risk for complications or a suboptimal result include those who are morbidly obese (visceral fat precludes a tight plication), have lung disease including severe chronic

Abdominoplasty

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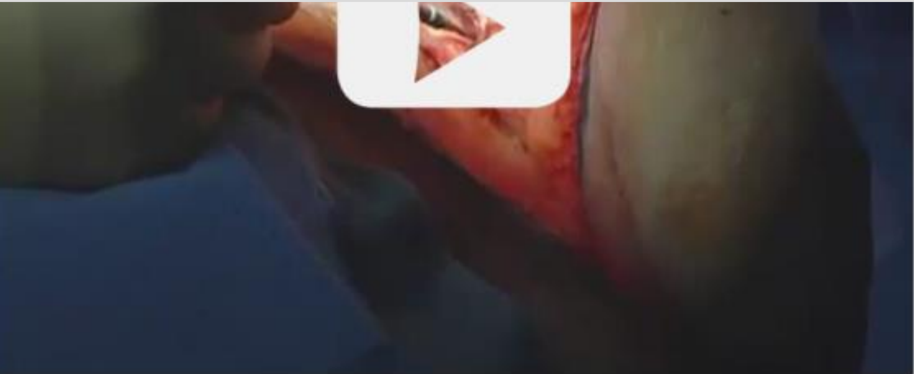

[Clip 1, Chapter 10] Circumferential Abdominoplasty

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Accompanying Videos. In: Strauch B, Herman C, ed. Encyclopedia of Body Sculpting after Massive

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Source: Abdominoplasty, Panniculectomy, and Belt Lipectomy. In: Hoschander A, Salgado C, Kassira W et al., ed. Plastic, Aesthetic and Reconstructive Surgery. 1st Edition. Thieme; 2016.

Abdominoplasty, Panniculectomy, and Belt Lipectomy

- Preoperative Markings
- Intraoperative Details
- Postoperative Care

Abdominoplasty

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Preoperative Markings|Intraoperative Details|Postoperative Care

Preoperative Markings

1. The patient should be marked in the standing position in the preoperative holding area.
2. Midaxillary lines and a horizontal waistline should be marked to ensure a symmetrical outcome.
3. For the lower border of the resection, the suprapubic line above the mons pubis is extended laterally in the groin crease. This line must be greater than 5 to 7 cm, superior to the vulvar commissure. From there, lines are extended toward the anterior superior iliac spine (ASIS) to stay within the bikini line.
4. An estimate of the superior border of resection may be marked preoperatively. However, an exact superior border of the resection must be drawn intraoperatively once the flap has been raised, the umbilical stalk freed, and the patient positioned properly to determine the appropriate amount of the resection.

Intraoperative Details

1. Incise the inferior elliptical border using a #10 scalpel. Extend the incision through the dermis with monopolar electrocautery on the pure cut setting, leaving the majority of dermis on the lower skin flap.

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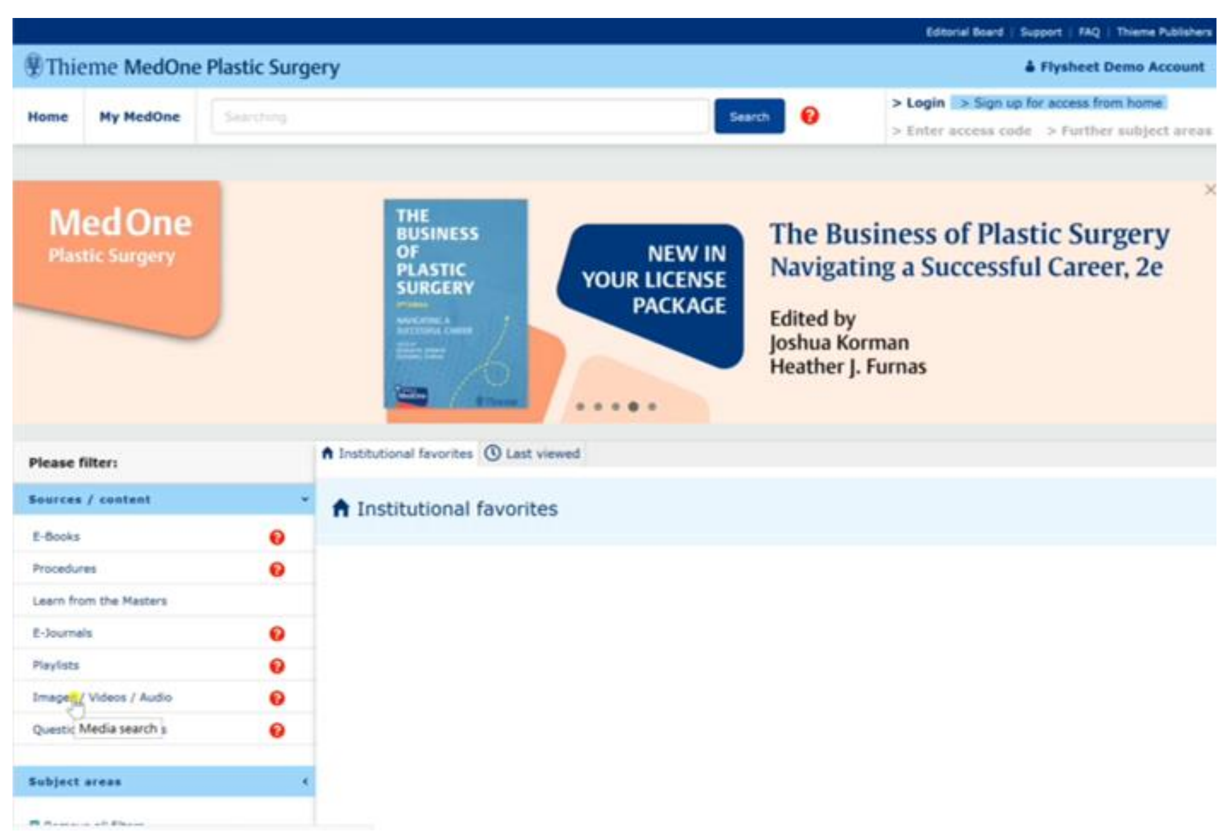

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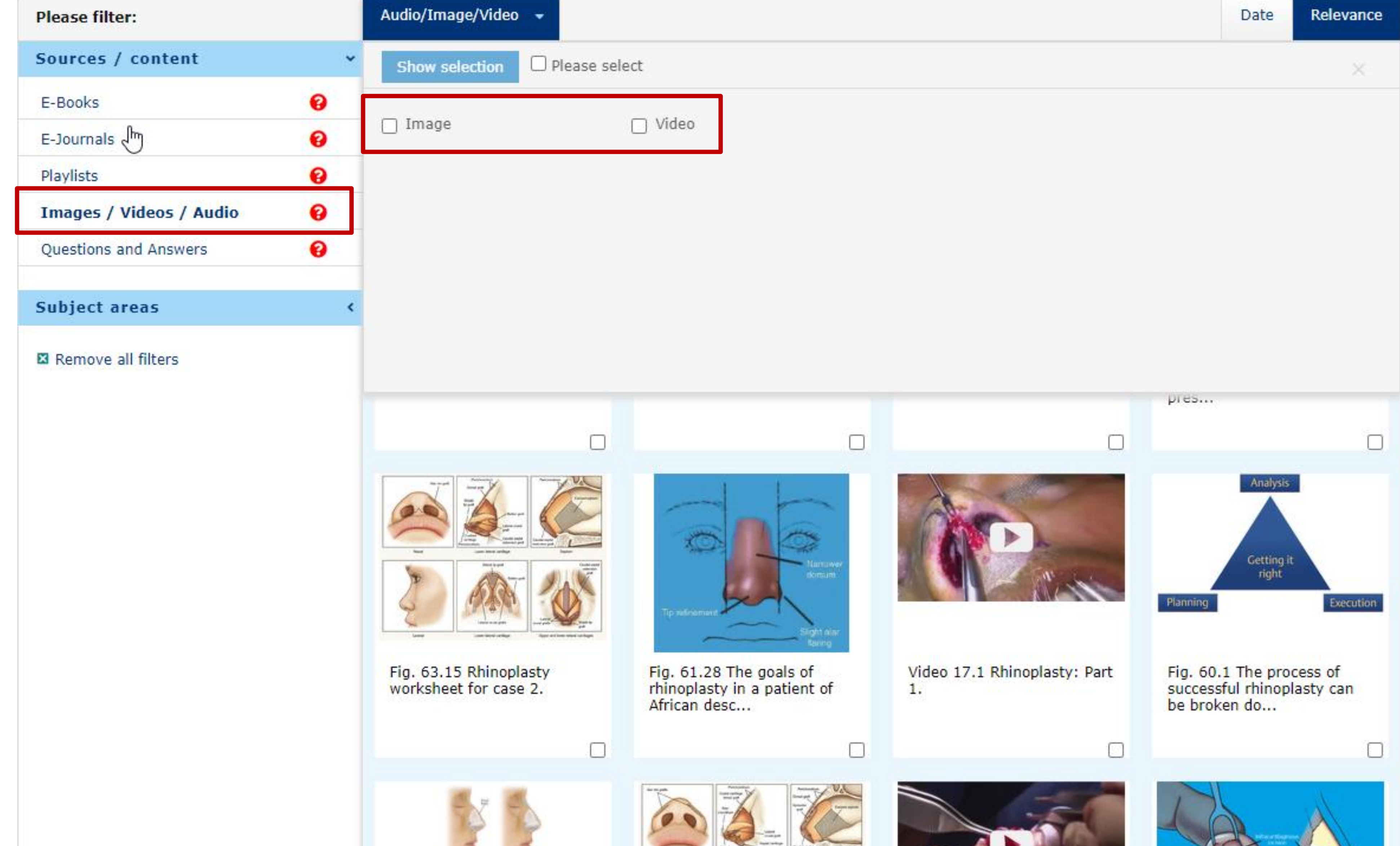

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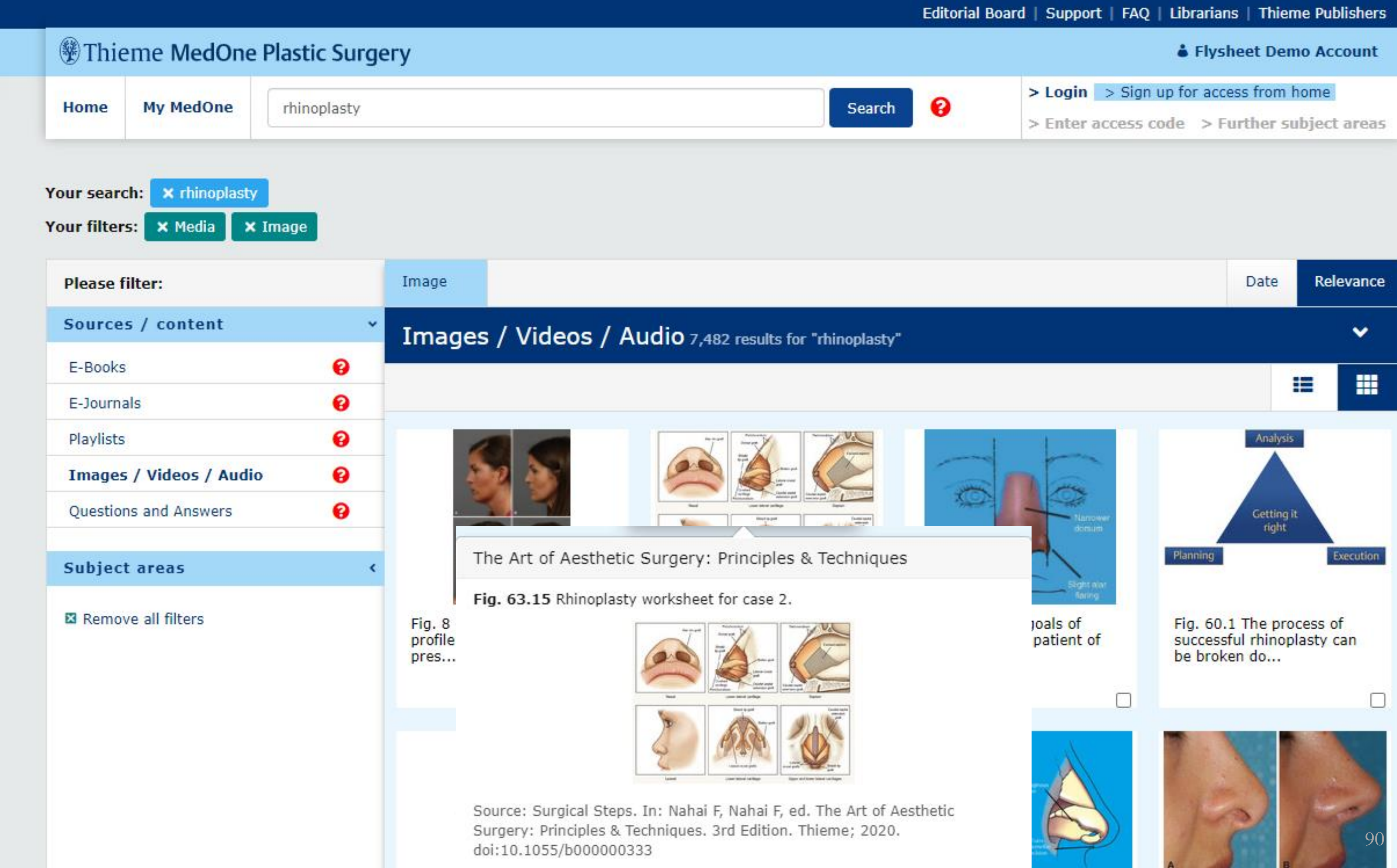

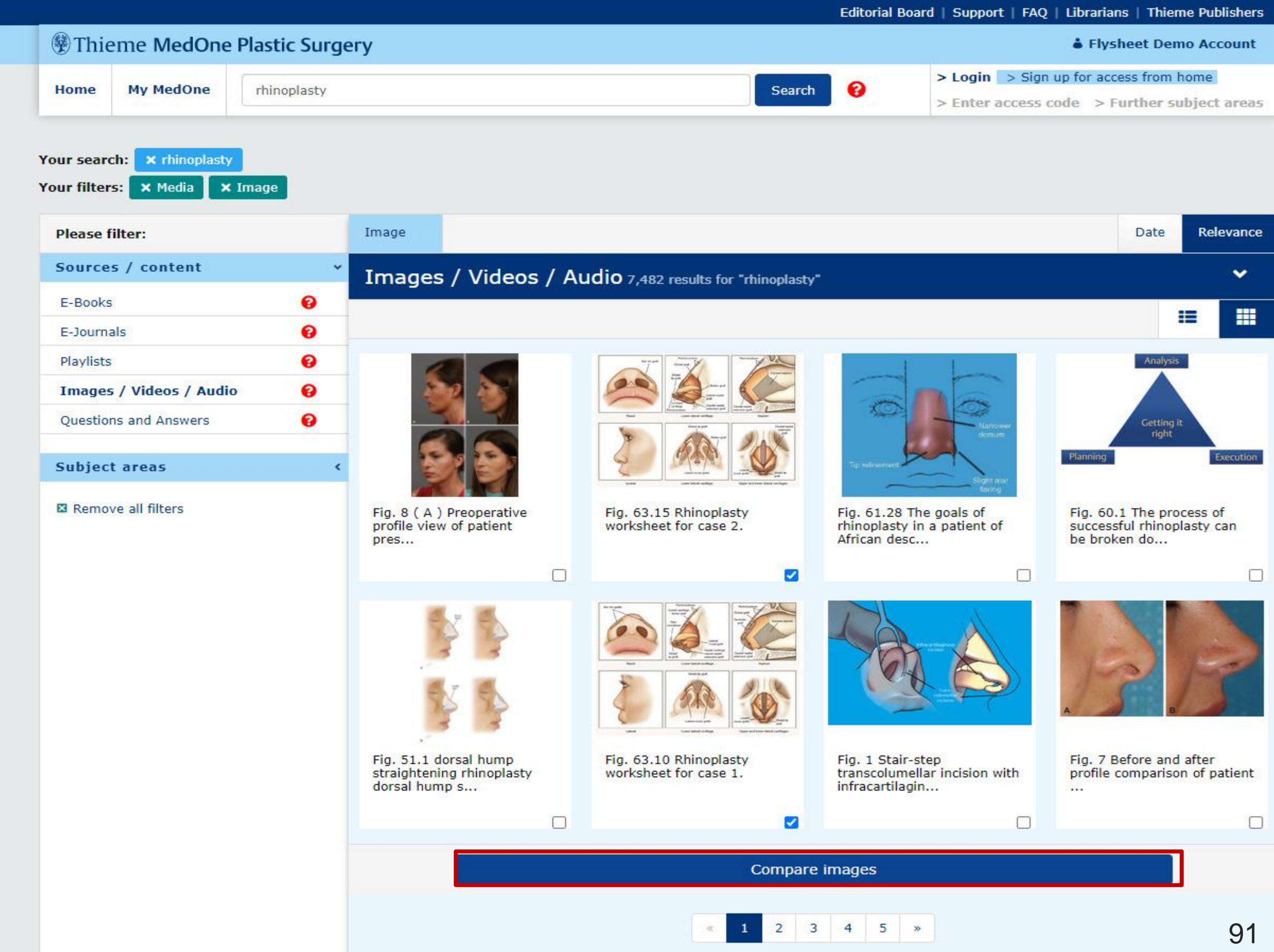

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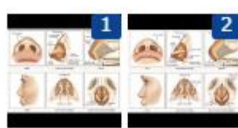

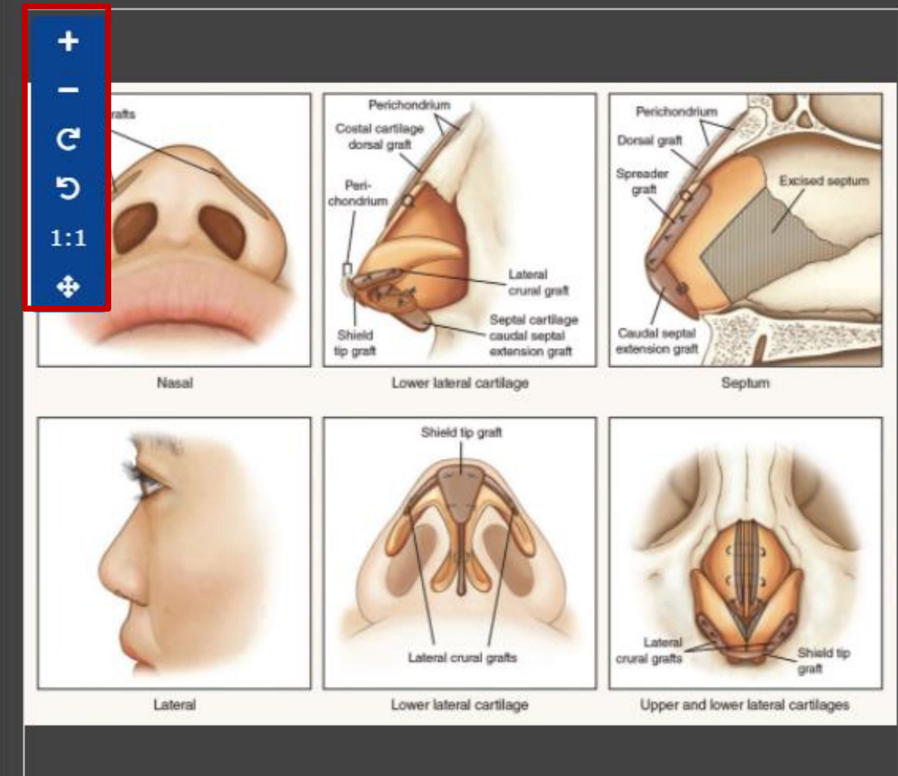

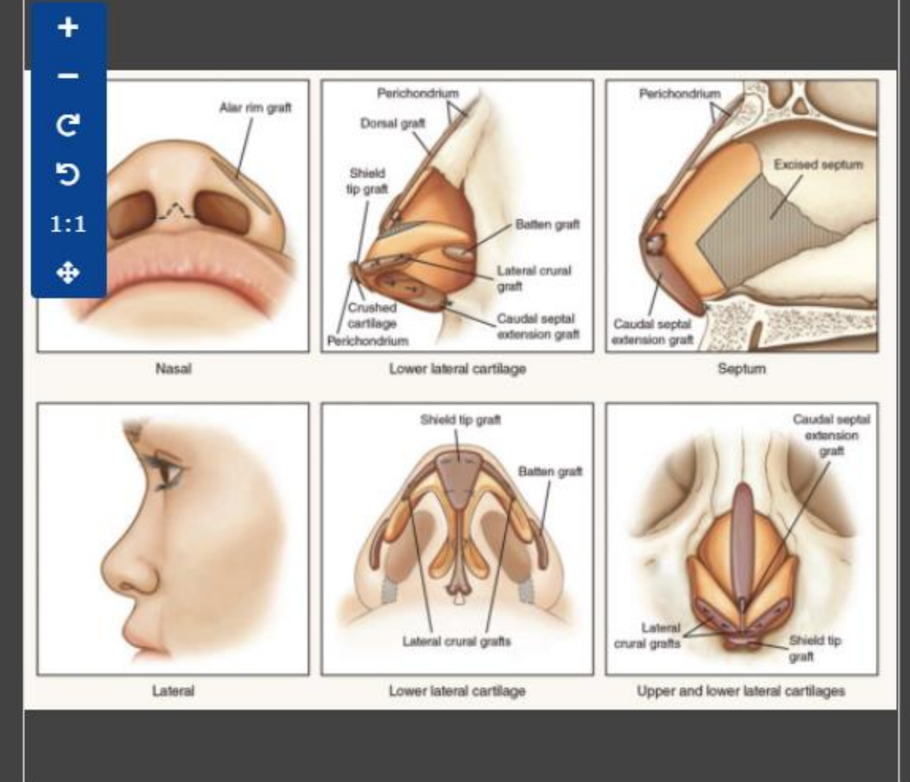

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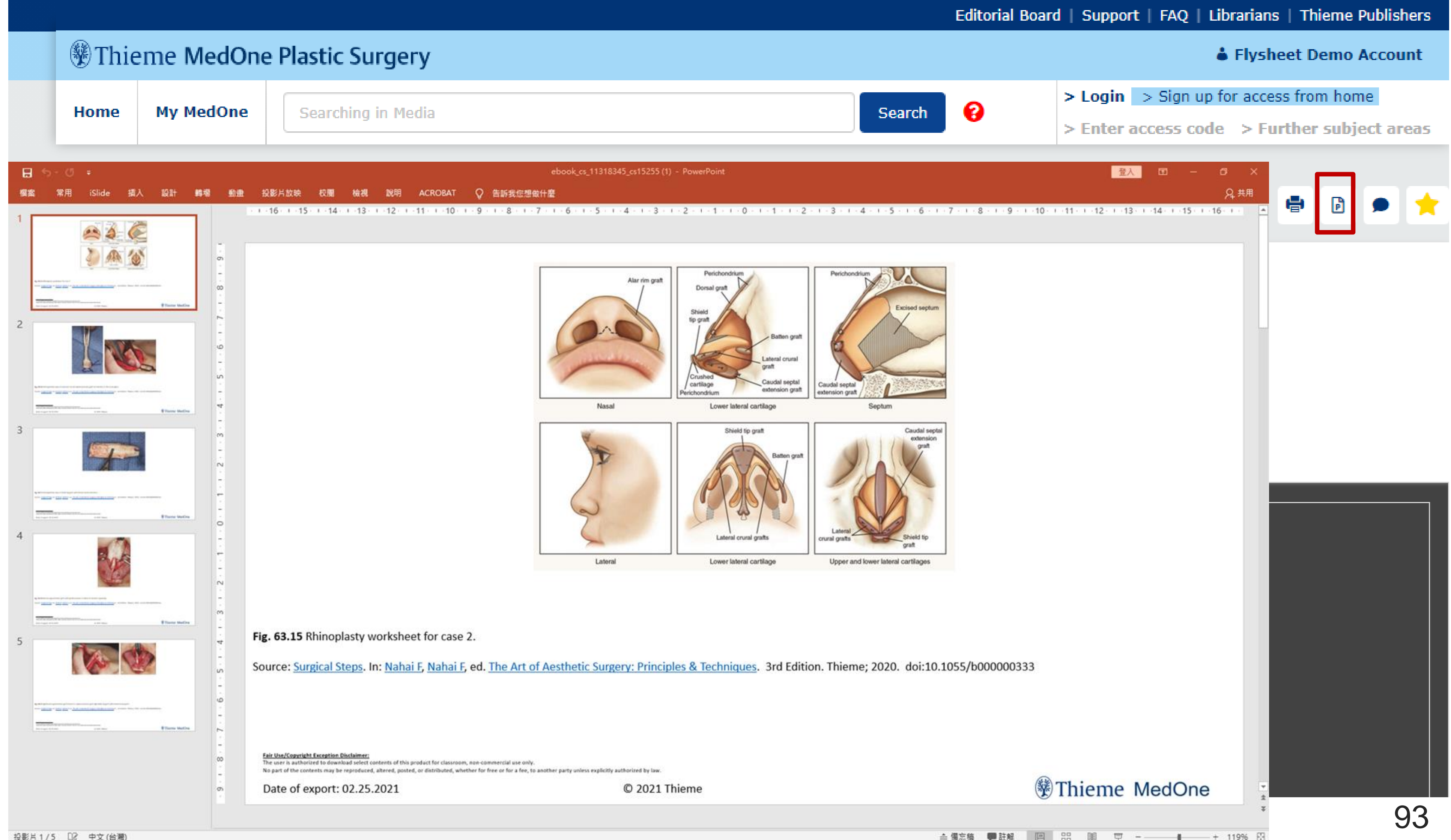

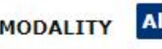

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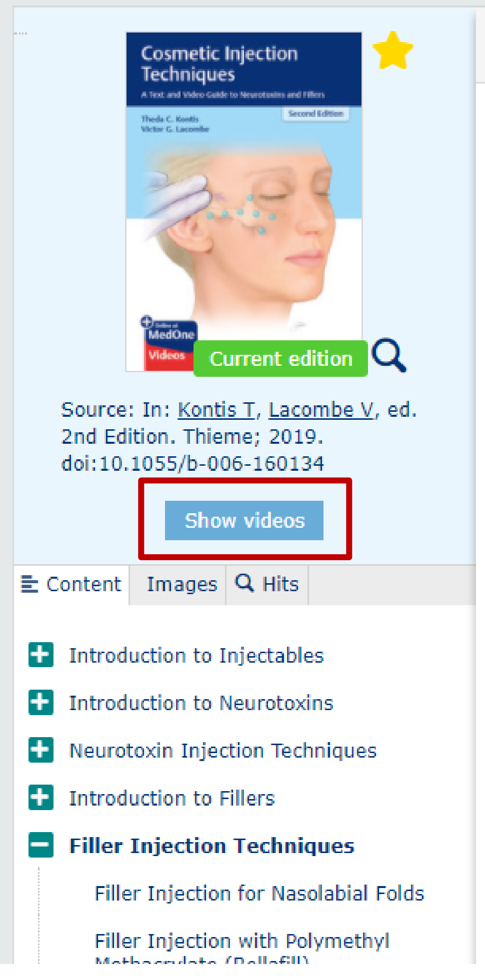

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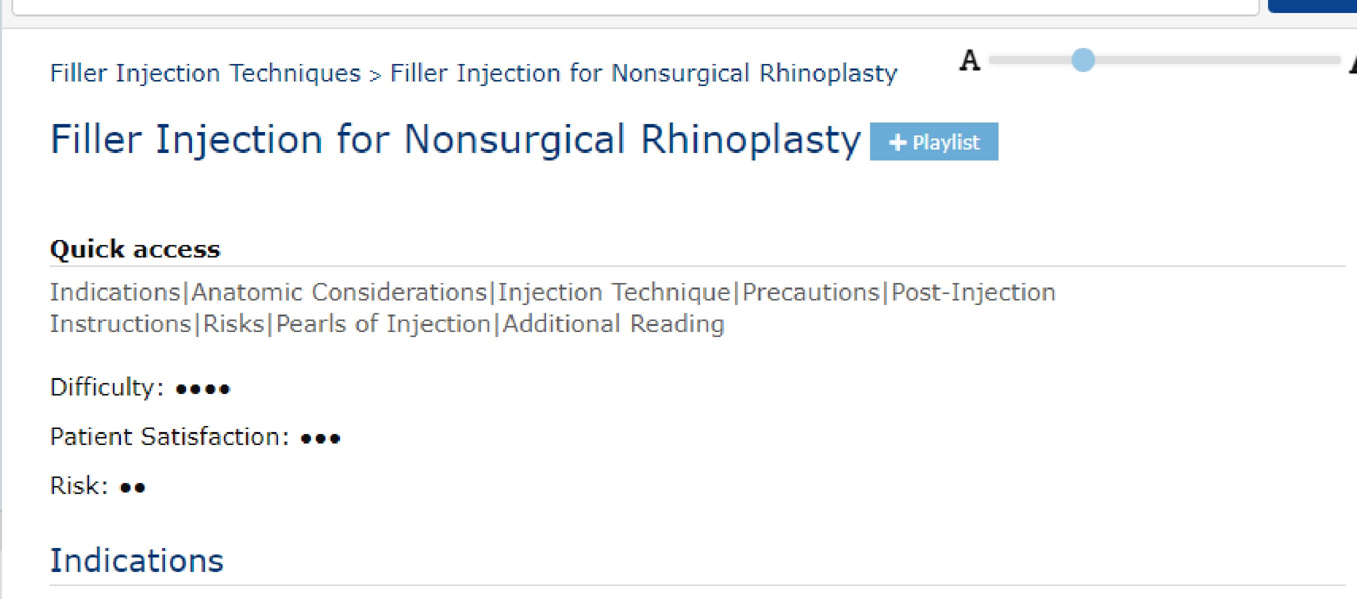

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Indications

Because the nose occupies the center of the face, even mild asymmetries can be quite striking. Rhinoplasty surgery is not always a perfect procedure, and postsurgical defects can be difficult to correct. As a result, the use of fillers in small quantities to treat specific nasal deformities has become a way to fine-tune postsurgical noses. In addition, in some patients who refuse surgery or who are not surgical candidates, a nonsurgical approach to their nasal concerns may be possible by the use of filling agents.

Anatomic Considerations

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[Video 38.4] Filler Injection for Nasolabial Folds, Marionette ...

[Video 19.2] Neurotoxin Injection for Glabellar Frown Lines and...

[Video 49.1] Filler Injection for Lateral Brow Lift

[Video 51.1] Filler Injection for Non-Surgical Rhinoplasty

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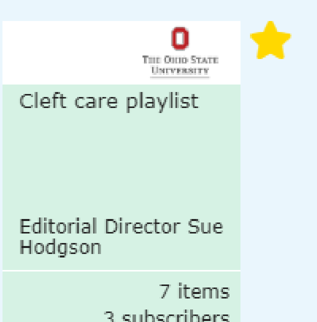

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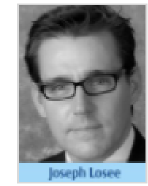


Content Collection

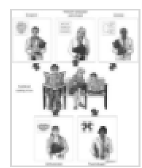
Joseph E. Losee

Comment: Cleft palate expert with videos

Video

Useful video

Source: Accompanying Videos. In: Bentz M, Bauer B, Zuker R, ed. Principles & Practice of Pediatric Plastic Surgery. 2nd Edition. Thieme; 2016. doi:10.1055/b-006-161029

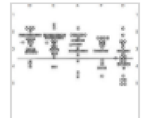


Chapter

Part I Fundamentals of Cleft Care

Part I Fundamentals of Cleft Care

Source: Part I Fundamentals of Cleft Care. In: Losee J, Kirschner R, Smith D et al., ed. Comprehensive Cleft Care. Family Edition.. 1st Edition. Thieme; 2015. doi:10.1055/b-006-160993



Chapter

Part I Fundamentals

Part I Fundamentals

Source: Part I Fundamentals. In: Losee J, Kirschner R, ed. Comprehensive Cleft Care. 2nd Edition. Thieme; 2015. doi:10.1055/b-004-140252

Chapter

Part VIII Primary Cleft Lip and Palate Repair

Part VIII Primary Cleft Lip and Palate Repair

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S. Douglas Steinbrech

Male Aesthetic Plastic Surgery

Source: In: Steinbrech S, ed. 1st Edition. Thieme; 2020. doi:10.1055/b-006-163729

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Steps for Male Rhinoplasty

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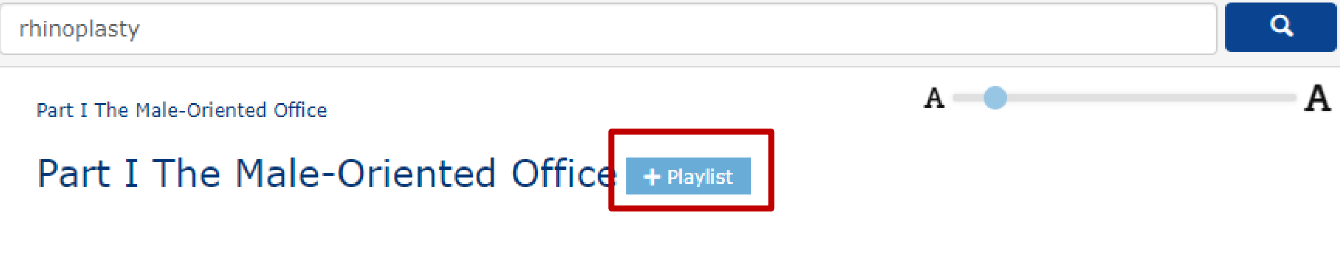
Management of Complications

CHAPTER 3 Virtual Surgery

CHAPTER 12 Chin Augmentation

Trends in Male Preferences for Aesthetics Surgery

rhinoplasty



Part I The Male-Oriented Office

Part I The Male-Oriented Office

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CHAPTER 1 Marketing Aesthetic Procedures to Men|CHAPTER 2 Photography for the Male Aesthetic Patient|CHAPTER 3 Virtual Surgery

CHAPTER 1 Marketing Aesthetic Procedures to Men

Thomas F. La Vecchia and Douglas S. Steinbrech

Summary

As an increasing number of men are undergoing aesthetic procedures, aesthetic surgery centers need to familiarize themselves with proven techniques for marketing to the male client. This chapter covers general marketing techniques, such as brand positioning and content generation, as well as how to develop a revenue-generating social media presence.

Introduction

X Factor Media was approached by Dr. Douglas S. Steinbrech in late 2013 with a new initiative. He wanted to roll out a website dedicated to male aesthetic surgery. At the time, we were a bit skeptical. Our research showed that men only constituted for roughly 9% of all aesthetic procedures in 2012. We were tasked with creating a website or an online resource (more or less). Male Plastic Surgery New York was born (www.MalePlasticSurgeryNewYork.com) (Fig. 1.1).

Our Approach: Build the Platform

X Factor Media started the campaign with reviewing the top procedures for men. According to the American Society for Aesthetic Plastic Surgery (ASAPS),[1] they are:

- Liposuction.
- Gynecomastia (removal of breast tissue).
- Eyelid surgery.
- Rhinoplasty.
- Facelift.

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Review Article

Anatomy, Exposure, and Preparation of Recipient Vessels in Microsurgical Head and Neck Reconstruction

Anatomy

Vessel Selection

Exposure Techniques

Anterior Triangle (External Carotid Branches, Internal Jugular System, and External Jugular System)

Submandibular (Facial Artery and Facial Vein)

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Journal of Reconstructive Microsurgery 2021; 37(02): 097 - 110

DOI: 10.1055/s-0040-1715644

Review Article

Xu, Hope[1]; Jazayeri, Leila[2]; Matros, Evan[3]; Henderson, Peter W.[1]

Anatomy, Exposure, and Preparation of Recipient Vessels in Microsurgical Head and Neck Reconstruction

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[1] Division of Plastic and Reconstructive Surgery, Department of Surgery, Icahn School of Medicine at Mount Sinai, New York, New York

[2] Department of Plastic Surgery, Kaiser Permanente, San Leandro Medical Center, San Leandro, California

[3] Plastic and Reconstructive Surgical Service, Memorial Sloan Kettering Cancer Center, New York, New York

Quick access

Anatomy|Vessel Selection|Exposure Techniques|Anterior Triangle (External Carotid Branches, Internal Jugular System, and External Jugular System)|Submandibular (Facial Artery and Facial Vein)|Intraoral (Facial Artery and Facial Vein)|Posterior Triangle (Transverse Cervical Artery and Transverse Cervical Vein)|Preauricular (Superficial Temporal Artery and Superficial Temporal Vein)|Chest (Internal Mammary Artery and Internal Mammary Vein[s])|Arm/Infraclavicular Region (Cephalic Vein)|Conclusion|References

Abstract

Successful microvascular reconstruction of head and neck defects requires the ability to safely identify, isolate, and utilize recipient vessels. To date, however, a comprehensive review of the anatomy and techniques relevant to the available anatomic regions has not been undertaken. This review covers the relevant clinical anatomy of the anterior triangle, posterior triangle, submandibular region, intraoral region, preauricular region, chest, and arm, taking particular care to highlight the structures that are crucial to identify while performing each dissection. Finally, a step-by-step technique for safely dissecting the recipient

Abdominoplasty

Source: CHAPTER 30 Abdominoplasty. In: Cohen M, Thaller S, ed. The Unfavorable Result in Plastic Surgery: Avoidance and Treatment. 4th Edition. Thieme; 2018. doi:10.1055/b-005-143642

CHAPTER 30 Abdominoplasty
- Avoiding Unfavorable Results and Complications in Abdominoplasty
  - Primary Goals
    - Removal of Excess Soft Tissue
    - Correction of the Rectus Diastasis
  - Secondary Goals
    - Scar Placement and Quality
    - Umbilicus
- Managing Unfavorable Results and Complications in Abdominoplasty
  - Seroma and Pseudobursa
  - Cellulitis and Deeper Infection
  - Flap Viability: Ischemia and Necrosis
  - Bleeding and Clotting
  - Patient Satisfaction
- Conclusion
- References

Avoiding unfavorable results

Joseph P. Hunstad and Daniel J. Krochmal

Quick access

Avoiding Unfavorable Results and Complications in Abdominoplasty|Managing Unfavorable Results and Complications in Abdominoplasty|Conclusion|References

The primary aims of abdominoplasty are restoration of a more ideal abdominal wall contour and removal of excess abdominal skin and soft tissue. Laudable goals of this procedure are to obtain an abdomen that is thin, tight, and flat. If a surgeon accomplishes these objectives, while achieving a relatively inconspicuous scar, an aesthetically pleasing umbilicus, and a complication-free recovery, a patient is usually quite satisfied with the overall result. If any of these goals are not obtained, the result may be unfavorable.

The “unfavorable” aesthetic results in abdominoplasty are usually correctable with revision procedures. With regard to actual complications, the more common ones are typically minor in nature and management is straightforward. The possible severe complications, including fatal pulmonary embolus, necrosis of the abdominal wall skin and soft tissues, and life-threatening infection, are rare.[1] This chapter presents prevention concepts for the more common complications and the unusual challenging complications, along with their management. Also discussed are some tips and tricks that have resulted in enhanced outcomes in our hands.

Avoiding Unfavorable Results and Complications in Abdominoplasty

The ideal patient for an abdominoplasty is an otherwise healthy, nonsmoking patient with a normal body mass index, a lax abdominal wall with rectus diastasis, and excess abdominal skin. Patients that are at higher risk for complications or a suboptimal result include those who are morbidly obese (visceral fat precludes a tight plication), have lung disease including severe chronic

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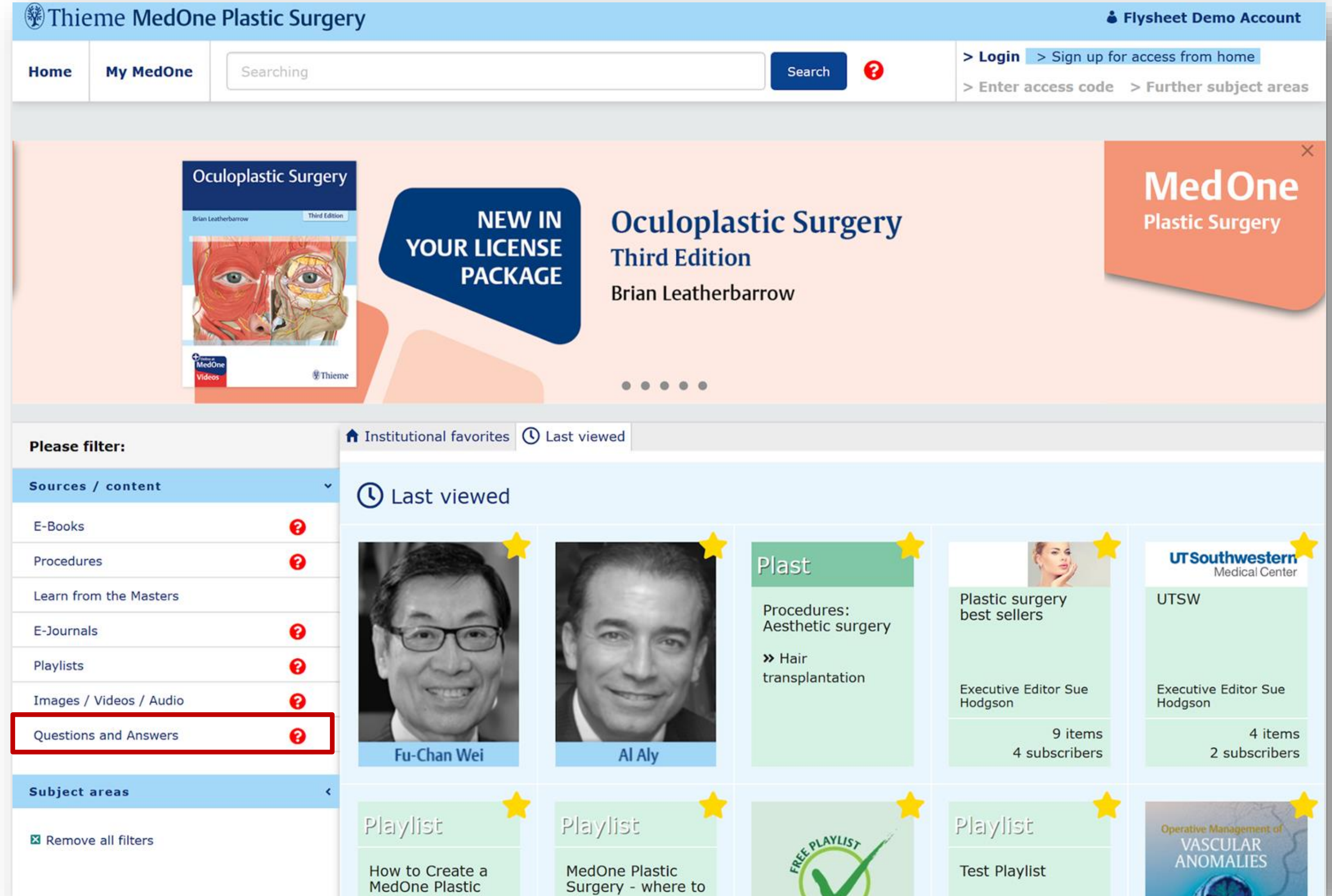

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Time per question (minutes)	1.5

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- Previously answered correctly
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Review session, 40 Questions

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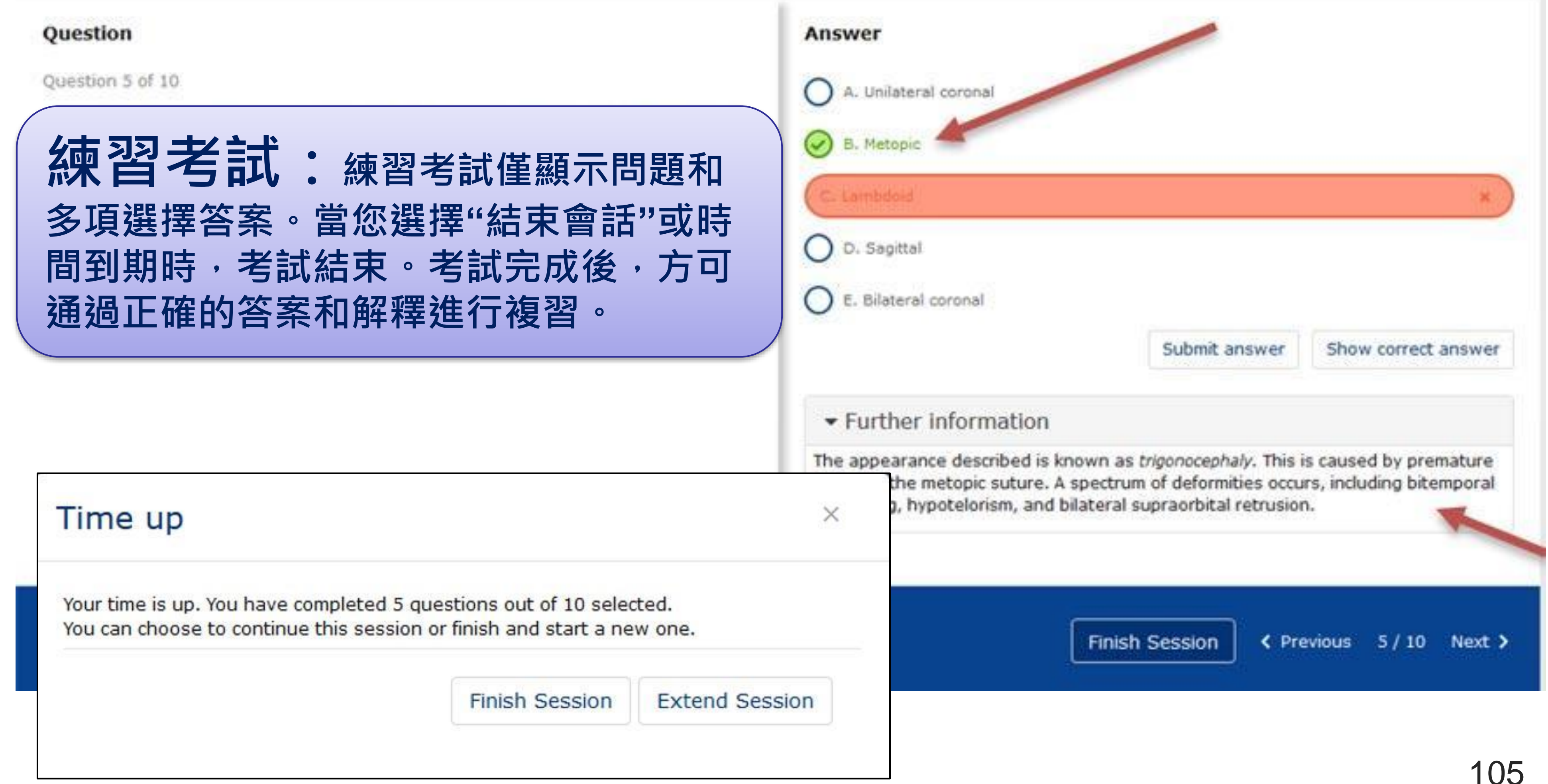
複習課程：通過複習課程，您可以查看每個問題的正確答案以及解釋。選擇答案後，單擊“Submit answer”按鈕，正確答案將以綠色顯示。錯誤答案以紅色突出顯示。單擊“Further Information”選項，可以查看與該問題有關的其他資訊。Extent Session可以增加時間。



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每個問題的時間是自動計算的。

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Session time (minutes)	60

Time per question (minutes)	1.5

確定問題數量和會話時長後，可以通過從下面顯示框中來過濾問題。

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- [ ] Plastic surgery of the skin and soft tissue
- [ ] Plastic surgery of the trunk and lower extremity

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Review session, 40 Questions

Start session

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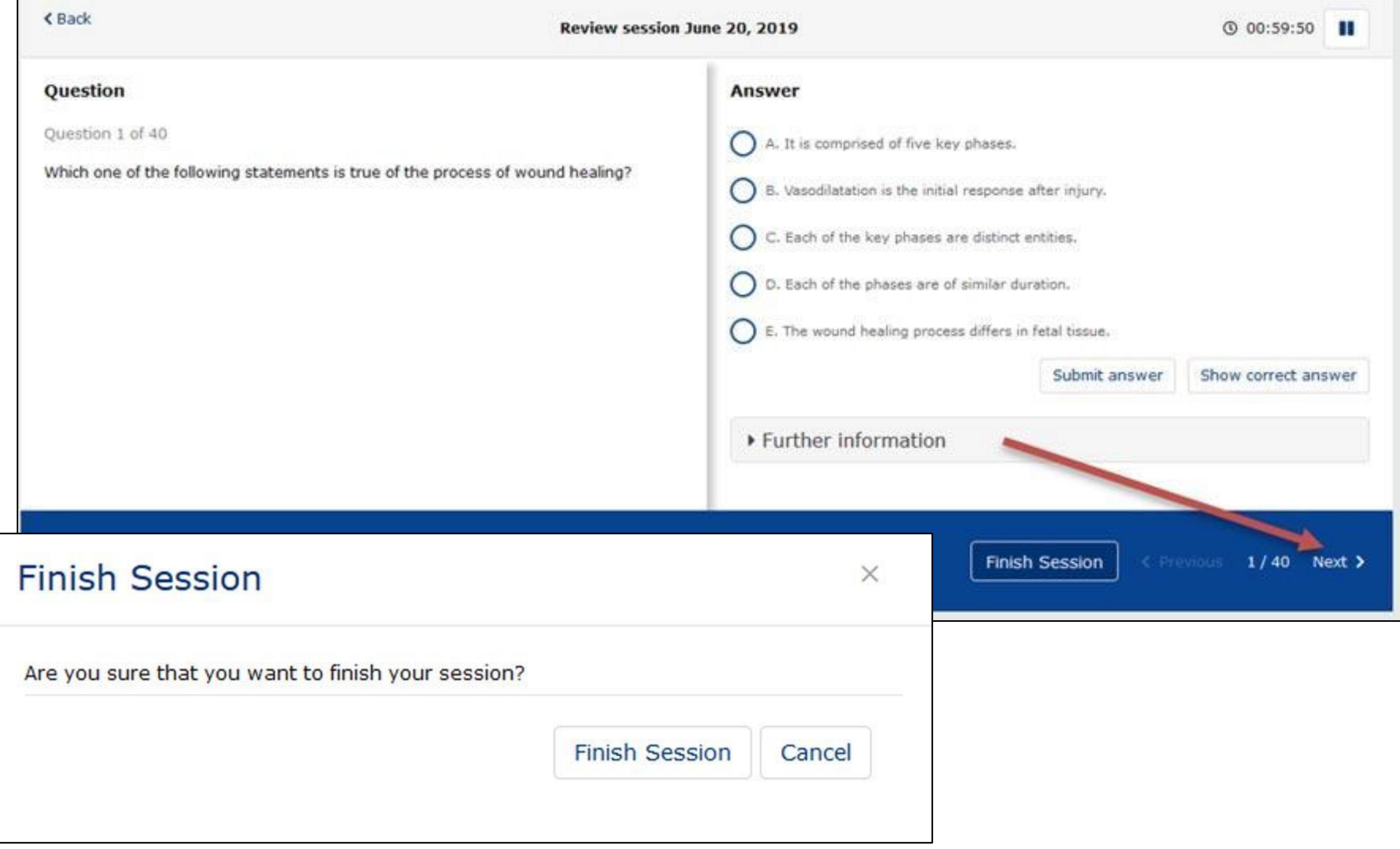

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Unanswered questions	0
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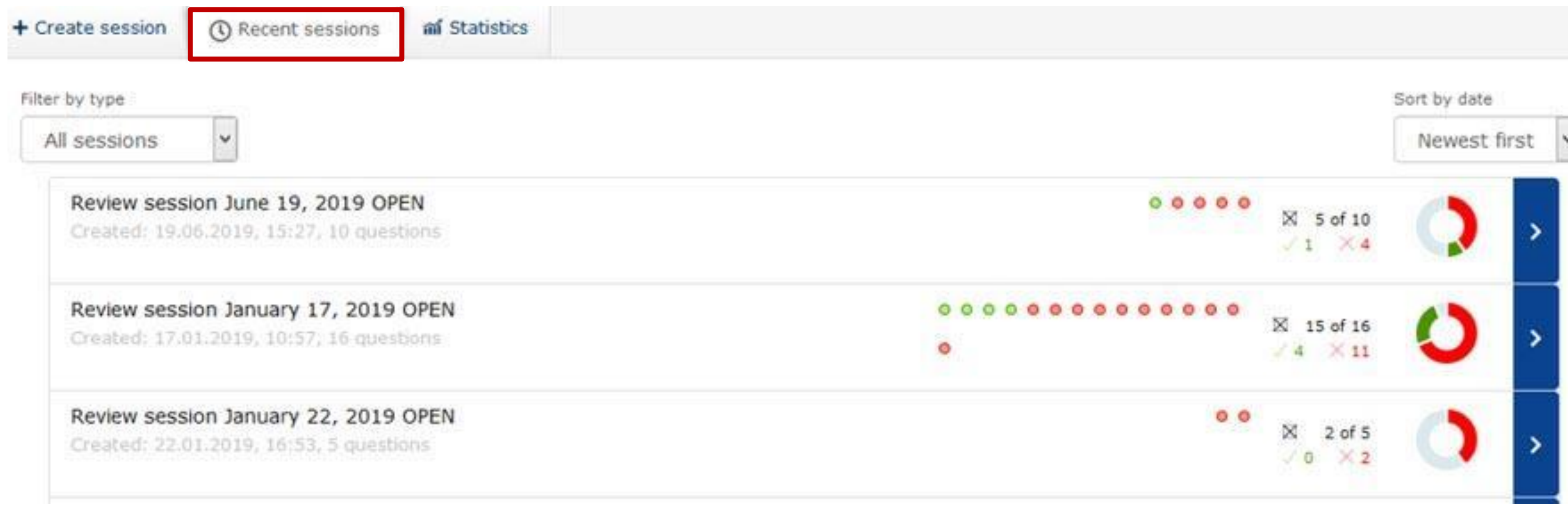

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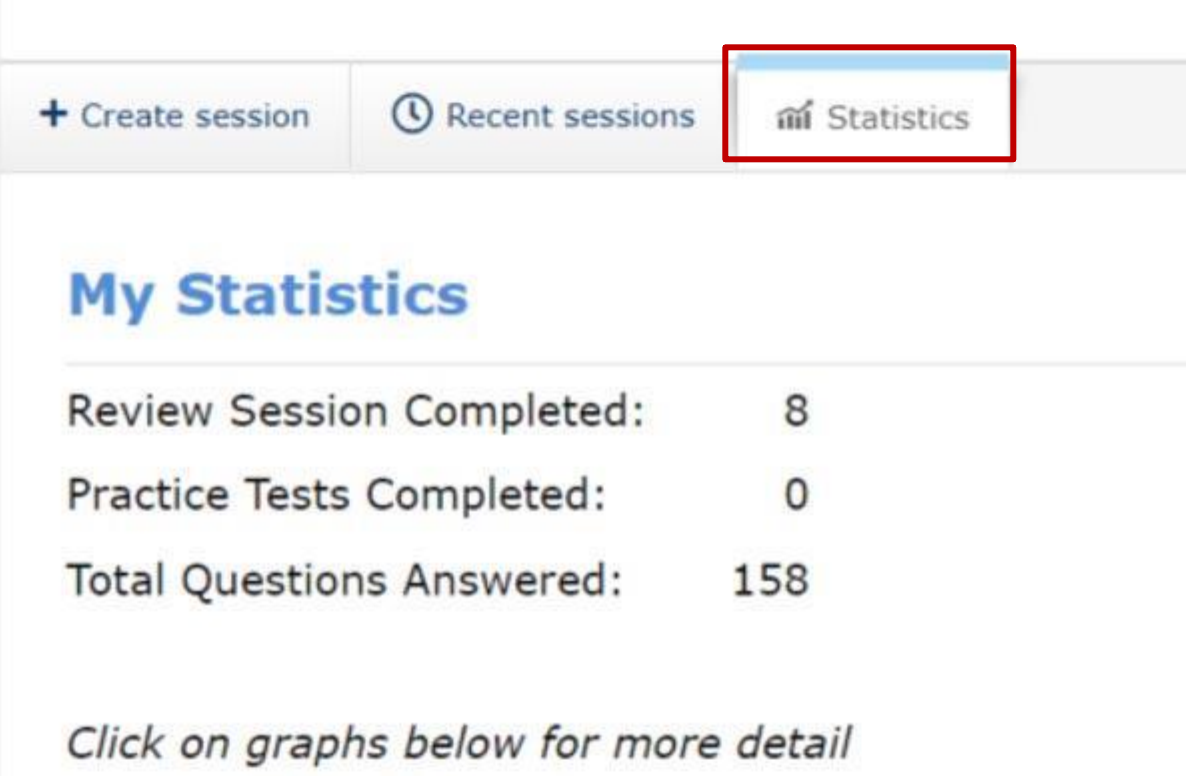

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