

A New Assisted Fixation Technique to Prevent Zygoma Displacement in Malar Reduction

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Received: 3 March 2013 / Accepted: 2 May 2013 / Published online: 30 May 2013
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Many techniques are used to reduce malar prominence, all of them very similar and described many years ago. The basic problem of the osteotomy is instability produced by the pedicle bone flap in the zygomatic arch because the bone flap has great mobility precisely due to the elasticity of the zygomatic arch. This mobility is increased by the masseter muscle activity that originates precisely at the lower edge of the zygomatic malar complex. Therefore, the direction of the bone flap and the vector of masseter muscle activity are the most important factors contributing to instability and inferior displacement of the zygomatic malar bone flap.

The described method is a good alternative because it gears the bone segments among each other. The structural problem present in the midface of Asian patients is an increase in the transverse dimension of the zygomatic malar complex, with a decreased anteroposterior midface,

which contributes to the appearance of the flat or concave faces of these patients. Sometimes a slight protrusion may appear in the maxillary segment because the projection level of the mid face is lacking in the piriformis fossa and paramedian region. Therefore, in these patients, the main objective should be to reduce transversal hypertrophy but with a simultaneous increase in the anteroposterior paramedian midface region.

The paper describes an adequate, good, and reproducible technique. The details of the technique are explained clearly with good photographic material. The proposed technique is very creative and effective in preventing malunion and cheek drooping. However, in reports on the causes of failures observed in other series and techniques, is there no reference about the expansive force of the temporalis muscle twitching inside the zygomatic arch? Would not the masseter's force be a strong factor in relapse?

Conflict of interest The author declares that he has no conflicts of interest to disclose.

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