



제 56차 대한악안면성형재건외과학회 종합학술대회 및 정기총회



The 56th Congress of the Korean Association of
Maxillofacial Plastic and Reconstructive Surgeons
November 3(Fri) – 4(Sat), 2017 | Global Convention Plaza, Seoul

Symposium 4



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Career

2011- Present Director of 22nd Century Medical and Research Center
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1996-Present Professor of Department of Oral and Maxillofacial Surgery, Graduate School of Medicine,
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1992-1996 Associate Professor of Department of Oral and Maxillofacial Surgery, University of Tokyo
1989-1992 Assistant Professor of Department of Oral and Maxillofacial Surgery, University of Tokyo
(1990 July - 1991 May Toronto Sick Children's Hospital, Plastic Surgery Division)
1987-1989 Chief of Plastic Surgery Division, Shizuoka Sick Children's Hospital
1985-1987 Chief of Plastic Surgery Division, Bokuto Metropolitan Hospital
1983-1984 Staff of National Cancer Center, Head and Neck Division
1979-1983 Residency-Plastic Surgery Division, Tokyo University Hospital and Hyogo Sick Children's
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Education

1973-1979 University of Tokyo, Faculty of Medicine (Graduate School)

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Craniofacial Surgery, Cleft Lip and Palate

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Conventionally, one-stage 2-jaw surgery combining Le Fort I osteotomy and mandibular setback surgery has been used to treat severe maxillomandibular discrepancy in cleft lip/palate patients. In some patients, stable occlusion and a good aesthetic outcome of this method are precluded by the presence of severely contracted soft tissue. Recently, maxillary distraction has been used for midface advancement in such patients. This technique allows the overlying midface to be advanced, because distraction osteogenesis gradually lengthens both the bones and the soft tissues.

However, the control of maxillary movement is difficult and the long wearing of outstanding distractors causes psycho-social problems. To overcome these problems, we had developed the two-stage surgery consists of maxillary distraction and mandibular osteotomies. The first stage entailed a Le Fort I maxillary osteotomy and placement of distraction devices. After a 4-7 day latency period, distraction devices were activated at the rate of 1 mm/day for 6–14 days. After the completion of distraction, the fixed devices were removed and the advanced maxilla was fixed with miniplates and mandibular setback surgery (sagittal-split ramus osteotomy or transoral vertical ramus osteotomy) was performed as the second stage. Class III elastics were prescribed for a few months after surgery to keep a correct occlusion.

The changes of speech were also examined from clinical records. Our two-stage surgery could improve occlusion as well as facial appearance without deterioration of speech. Skeletal relapse was acceptable and it had been covered by orthodontic treatment. This method can minimize patient's burden due to wearing distractors. Approximately 1 year after midface advancement in such patients, rhinoplasty is to be performed. In severe nasal deformities, augmentation rhinoplasty with using iliac bone graft (cantilever bone graft), nasal tip plasty with septal cartilage and /or several touch up operation is used with satisfactory results.