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ABSTRACT

The value of non microsurgical procedures covering facial tissue defects

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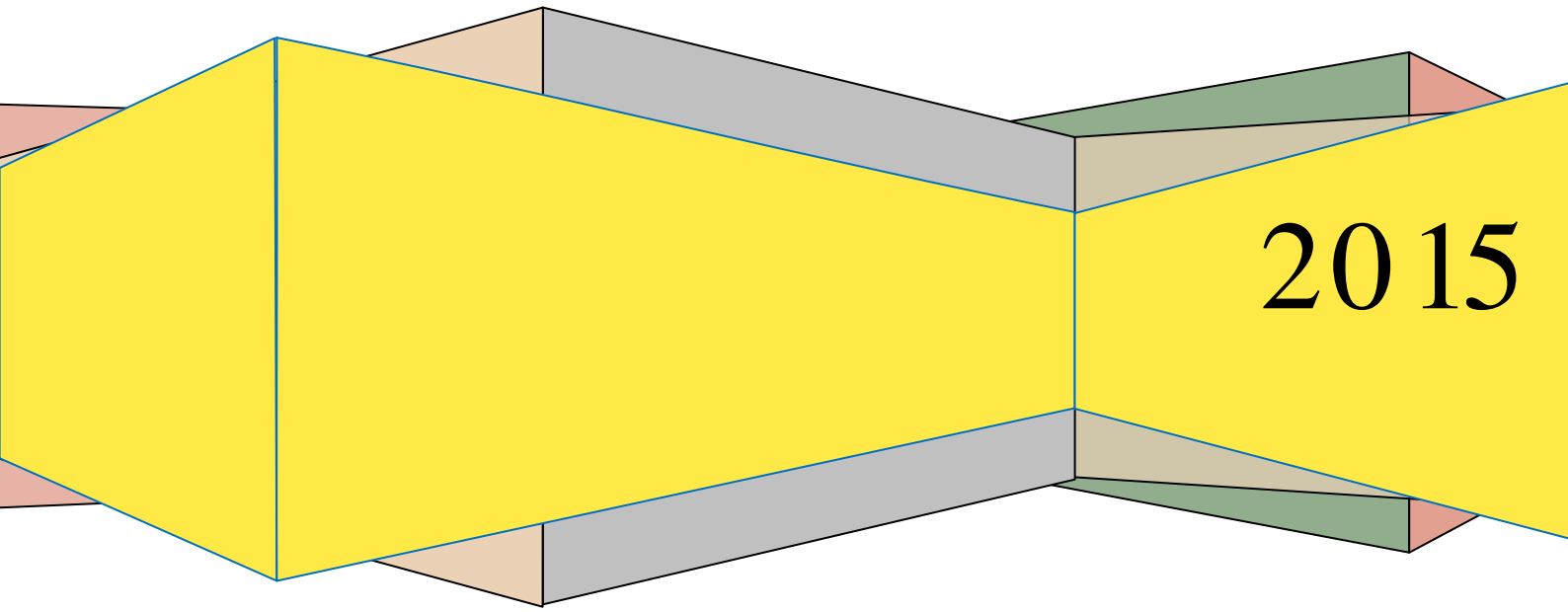

General Part

HISTORY

Plastic surgery origins are lost in ancient history because "history is the history of man's struggle surgery to treat injuries caused by nature or sow" [1] Concerns for replacement body parts diseased or traumatized represented a dream of man for centuries - there is evidence tansplantului from animals to humans in Greek mythology and legend saints "doctors without silver" (Cosmas and Damian) has a transplantation of a leg a Moorish servant of the church.

There is clearly some difficulty reconstruction the loss of the face and the difficulty lies in the fact that besides getting a fair functional outcome as and achieving an aesthetic quality. [2]

Due to its crucial role in shaping the face countenance any failure requires correction or recovery morphofunctional to thereby be able to play those mental balance after a surgical excision or trauma feel complex family and society [3]

Today it is widely accepted that the defects of soft parts of the face are a growing various reasons: traumas, wounds bitten, especially following excision surgery required frequency ever-growing tumors skin or soft tissue.

Technical palette and surgical procedures has made today can be positively solved a number of problems 3-4 decades ago it seemed impossible.

Any small changes in their facial plastic surgeon is a concern and it is extremely important since the restoration of form and function (the reconstruction) contributes to faster social rehabilitation of the patient and thus induces the well [4.5] face is a mosaic of shapes, protrusions and

depressions inducing lines light reflection areas and areas of shade that gives individuality.

Reconstructive Surgery (reconstructive) defects of the face has a wide range of surgeries and surgeries require the surgeon great finesse inspiration, vision, ingenuity and aesthetic sense all accompanied by strong surgical competence and experience.

Repair soft tissue defects particularly those characterized by loss of substance and contour defects is a major problem for contemporary medical practice.

There are very many medical conditions that lead to defects, however, subcutaneous fat and / or dermis and when necessary to replace lost soft tissue and restoring the physical form of free Gras physiological function through transplantation.

Concerns surgeons to correct or reconstruction of facial defects dates from ancient times (1000 BC the year -in India) and spread these concerns in India started going through the scientific world and the Persian and Arabic Hebrew scholars to migrate to Rome and then to Europe and some of techniques are used today [6].

Clearly there is a close connection between facial anatomy and surgical coverage methods that can be used for reconstruction of secondary faults so exact knowledge of anatomy is extremely important [7].

Renaissance through extremely valuable anatomical studies that have changed the vision of the anatomy that transforms a galenical discipline in one essential vesdiană thus influencing attitudes in plastic and reconstructive surgery allowing the development of local flaps or distanţaă (segmental vascularisation).

As an irony of history, the Enlightenment era was the age of enlightenment and not for plastic surgery in this period being proscribed proposing a series of works that nose reconstruction using flaps remotely - ie the arm [1].

"Golden Age" of plastic and reconstructive surgery can be appreciated in the decade 1960 -1970 when they were imagined and put into practice a number of surgical techniques, rapidly increased the number of plastic surgeons and for the period 1976-1983 to plastic and reconstructive surgery Pioneers cranio-maxillofacial surgery and the development of antibiotic aseptic and plastic surgery have changed essentially results in conjunction with technical progress in the development of innovative suture materials.

In 2005 it realized the first transplant partial face (Devauchelle and Dubernard) in a patient 38 years with a complex defect of the face by a dog bite; currently being reported over 200 cases of transplants to worldwide .

A new therapeutic direction in reconstructive surgery is the regenerative medicine initiative represented by autologous fat transplantation due to its rich content in stem cells.

Prestige plastic surgeons in the medical professions as well as in public opinion has made a major leap in the results obtained surgeons repairers during a world war or regional [8] when they occurred and have won multiple methods reconstruction after settlement mutilation recorded.

In terms of teaching can be said that there are two essential components of surgical plastic surgery: a component reconstructive which is actually an attempt to restore the individual to normal and part aesthetic cornerstone attempt to exceed normal but, theoretically, the problem will never be solved not in the sense that the act can be surgically predominantly aesthetic or

reconstructive can be mixed but most important is that both contribute to good surgical correction.

Aesthetic sense and ingenuity reconstructive plastic surgeon in interventions is underlined by Aristotle brilliantly saying "art really lies in the concept that the effect occurs before its material realization" [1] This is perhaps the most important for your plastic surgeon; What differentiates it is quality technician for the learner for plastic and reconstructive surgeon whose talent is innate or is absent and can not be formally taught.

The axiom that tissue must be substituted by another similar tissue [9] which is why for many years depressions correction of tissue from different areas of the body was done with autologous adipose tissue or dermogrăsoase free transplants.

The reconstruction of facial defects is a theme widely debated and studied over time but especially in the last 50 years, due to the complexity defects resulting from extirpation of tumor lesions at this level associated with the impact that it has the result that reconstruction of point aesthetic (cosmetic).

Trouble with immediate reconstruction playback functionality physiognomy and facial ensure postoperative The patient quality of life and social reintegration top [10].

Reconstruction using local or remote resources best meet the requirements and objectives of reconstruction defects of the face and, in addition, allows immediate reconstruction early initiation of treatment in patients oncological (radiotherapy possible).

The plastic surgeon should be aware that any reconstructive procedure involving the skin entails a risk for the appearance of scarring and unlike

other surgical specialties here these scars are permanent visible to the patient and the environment.

When we see a person with a facial scar our eyes are instinctively drawn to it and the mind leads us to the story that lies behind it [11].

Facial Aesthetic surgery can correct many changes associated with aging which in addition to their unattractive appearance, affect mental patient anatomy and function can depreciate [12].

The most difficult task of the plastic surgeon before a problem of covering a defect of skin or soft tissue is determining surgical indication given that technical options are varied: close the direct use of transplants free leather (split or full thickness) using Local flaps (the random movement, axializate, fasciocutaneous and myocutaneous) flap or specialized (composite, re-sensitized).

Although past millennia until plastic surgery has defined the actual identity, its major objective remains restoring the shape and function of local government.

Currently, standards for assessing success in plastic surgery should include mandatory mental patient satisfaction and socio-professional reintegration coefficient thereof.

Coating method TISSUE DEFECTS IN THE FACE

- The choice and use one of the many ways of covering tissue defects of the face is determined by the actual needs of the region that must correct [34,35] and, in time, the clinical experience of the surgeon or surgical service.
- The difficulty of solving the defects in tissue on the face lies in trying to achieve not only a result convenient in terms of functional and aesthetic, as the flaws of the face - in particular those from the nasal pyramid - are generally complicated and include complex functional structures and all this together with the fact that the face is the main characteristic of each individual segment.
- In solving management flaws postexcizionale anticipated postoperative appearance of the face is a factor to be taken into account in the preoperative assessment and planning of the operation or operations [36,37].
- The therapeutic plan to cover tissue defects of the face is absolutely necessary to be performed before treatment; it is individual stages and must include ways of solving problems that might occur during surgery.
- The therapeutic plan must assess the risks and provide possible complications, must also choose the best solution for this case and by all existing risk factors [38].
- In surgery to cover tissue defects of the face is another important principle that the surgeon have to consider is choosing the donor area -

where necessary - should be used where possible the secondary functional deficits to be the least troublesome.

- In choosing surgical procedure repairer surgeon must be extremely careful in selecting cases based on the complexity of the process to be used, given the need for the patient to understand the risks of the surgery and to judge correctly and objectively, deliverables but basically it is important to cooperate with the patient [39,40].
- The surgeon addressing the region face, be it cosmetic surgery or reconstructive surgery should be familiar with the location and distribution voltage line of skin, position and exact boundaries of "units" aesthetic facial and vascularisation face [41 42].
- To achieve a functional result and aesthetic best Millard argues that it is preferable to carry (even with excision additional) excision of the entire unit Aesthetic and then to carry out reconstruction of its total although incumbent surgery complex and sometimes multiple (surgery serial).
- Reconstruction of any region of the face must be addressed systematically, given first the simplest methods and only then increasingly more complex, depending on the local aspect (especially postexcizional) [43] and to consider various aspects such as: type and aggressiveness of the tumor, previous treatments, general health status and its cooperation [44,45].
- The diversity and complexity of methods of reconstruction of the face - it is about rebuilding tissue defects traumatic and / or postexcizionale - starts from simple to complex, depending on the size and complexity

of the defect is envisaged and facial area concerned (it is one facial aesthetic areas).

- In accordance with those principles in surgical practice can use one of the following methods in the reconstruction of tissue defects of the face.
- **Sores DIRECTED**

• Simple excision and suturing the wound edges

• incision and suture mobilization BY PERIPHERAL DEPARTURE

• transplants FREE SKIN

• FREE composite tissue transplants

• locoregional flaps

• triangular flaps

• TISSUE EXPANSION

• tissue augmentation

• AUGMENTATION BY TRANSFER autologous ADIPOSE

• AUGMENTATION by injecting synthetic products

• pedicle flap

• MICRO-surgical flaps free transf

The personal part

RESULTS –DISCUSSION

This study was conducted on internal and specialized caseload handled Surgery Clinic of Plastic and Reconstructive Microsurgery Constanta County Emergency Hospital between January 1, 2010 to December 31, 2014 comprising a total number of patients admitted and treated 12423 cases.

Of the total number of patients hospitalized and some were treated on the "admissions day" or a total (the range stated above) of 7169 cases and in the "continued internment" a total of 5254 cases.

From the point of view of the annual distribution is as follows:

* 2010 ----- 1071 hospitalizations day; 890 continuous hospitalization
* 2011 ------ 961 day admission; admission continues 931
* 2012 1237 ------ daily admission; admission continues 970
* 2013 1731 ------ daily admission; admission continues in 1359

2014 2199 ------ daily admission; admission continues in 1101.

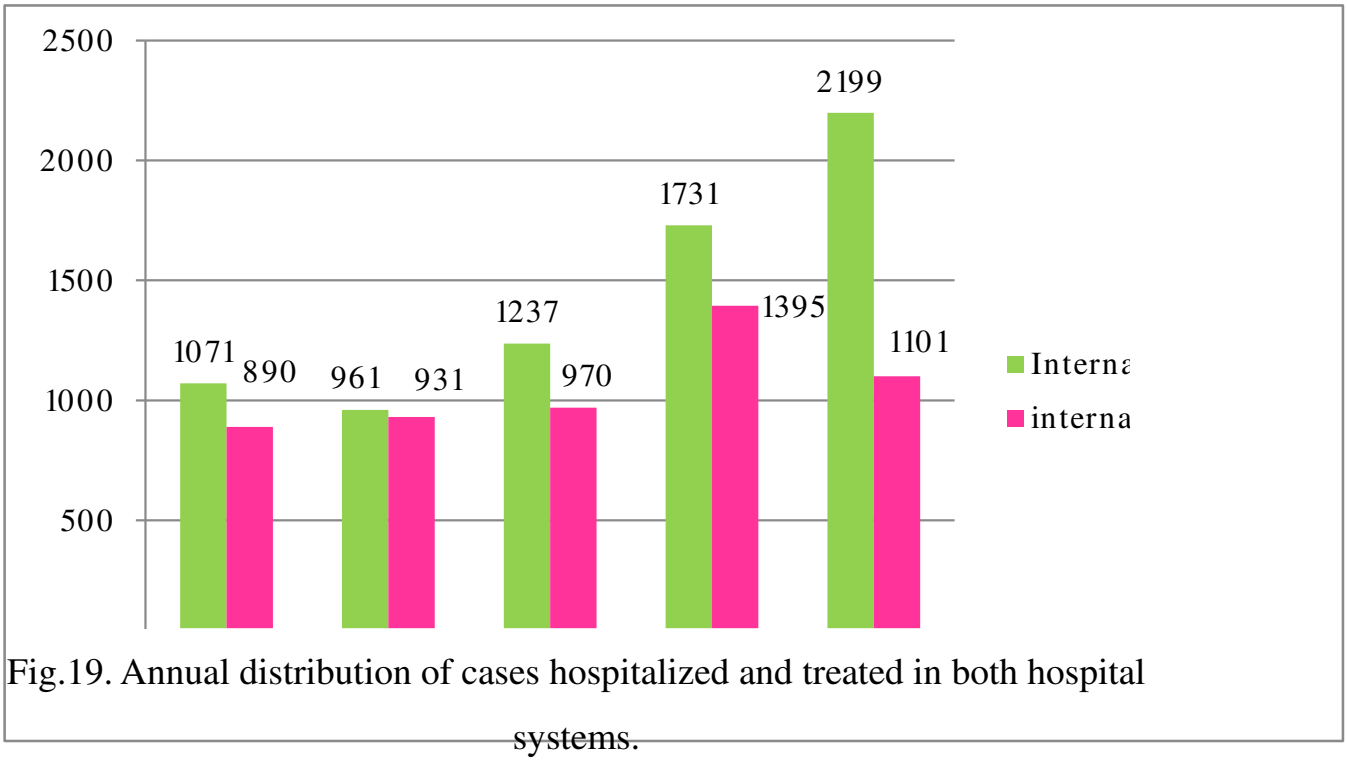

Fig.19. Annual distribution of cases hospitalized and treated in both hospital systems.

Given that the criteria for inclusion / exclusion has been clearly established that in the present study included patients who had a defct skin / soft parts of the face below the 1.5 -2 cm 2 and that could be solved simply by stapling Trouble is logical that our number of patients in the lot that is 584 to be compared - in order to obtain statistically elements right - with numărulu total patients who received continuous hospitalization.

To determine the percentage of the average total number of patients with continuous hospitalization and total number of cases in the study should compare 5254 patients with 584 cases representing, speaking percentage 11.1% and is plotted

below.

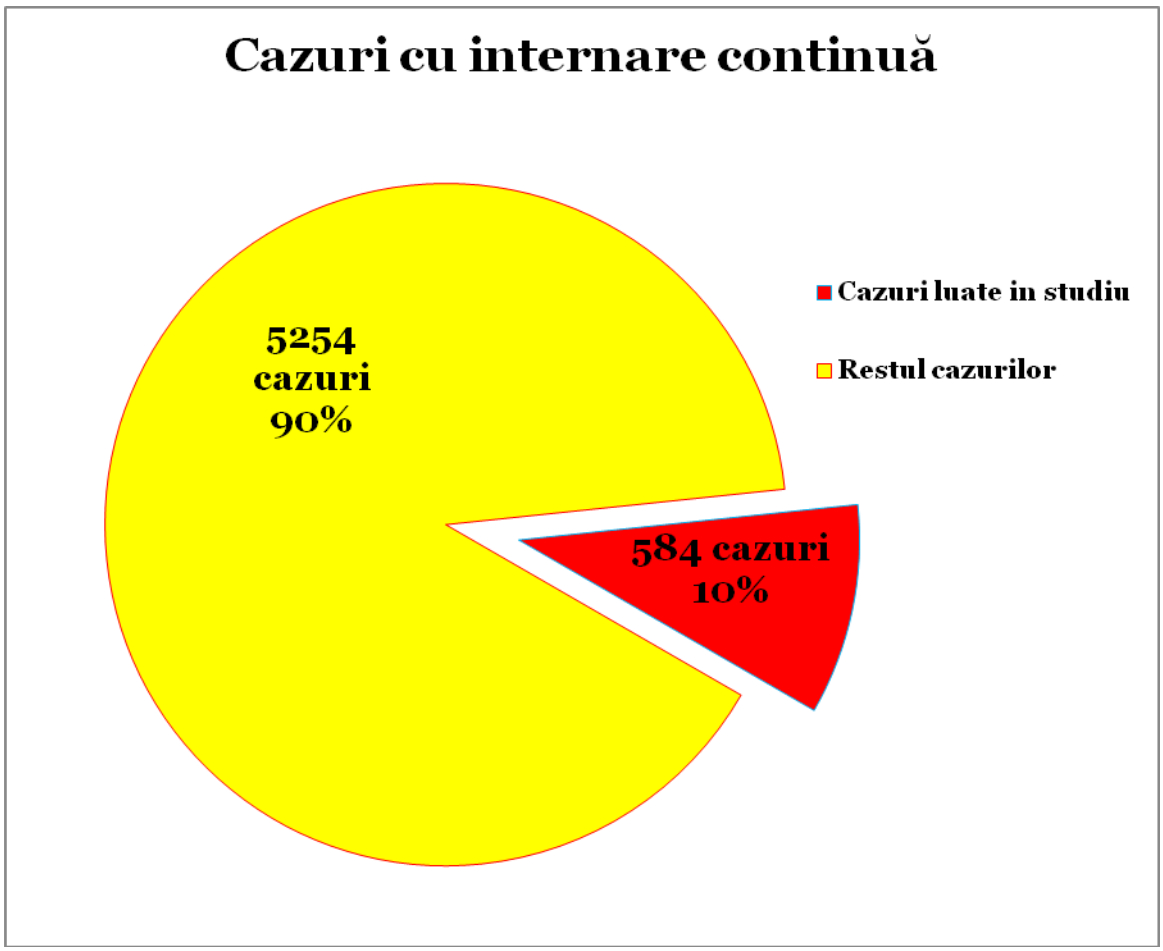

Fig.20. The total percentage of cases of patients with continuous admission.

The study group, ie 584 patients were assigned to calendar years as follows:

* 2010 ---------- 88 cases

* 2011 ---------- 95 cases

* 2012 ---------- 104 cases

* 2013 ---------- 127 cases

* 2014 ---------- 170 cases

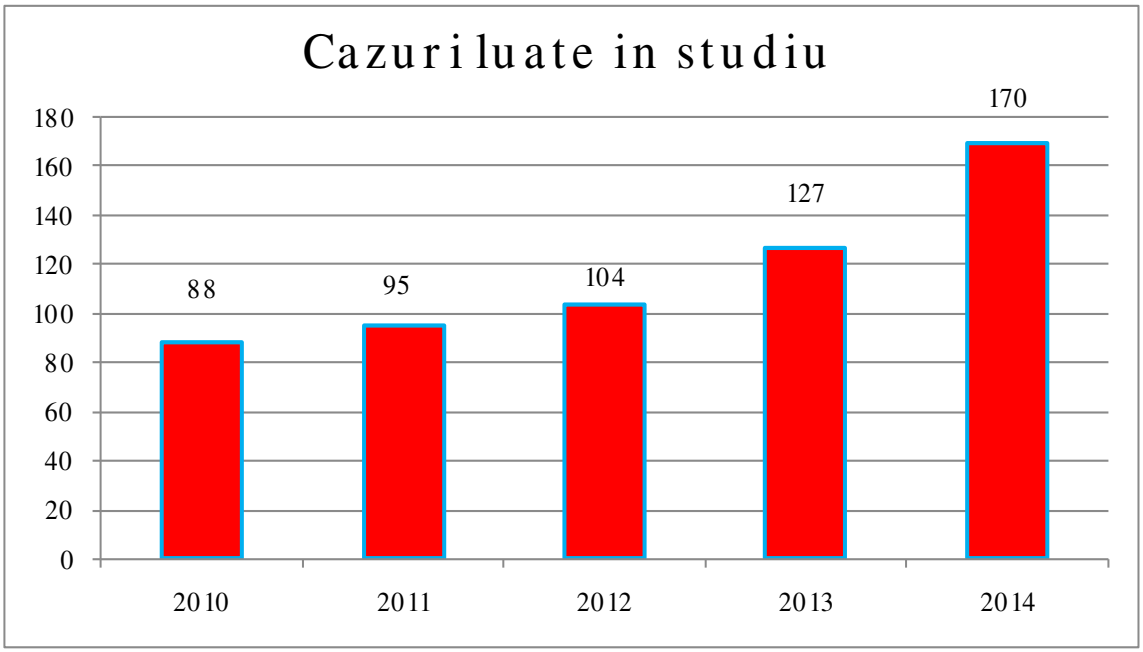

Fig.21. Distribution by years of cases in the study group

In order to ascertain what percentage of the study group representing patients of all patients who received continuous hospitalization we calculated each calendar year partly effective percentage, ie:

* 2010 No. total 890 cases / instances lot 88 percentage 9.88%;

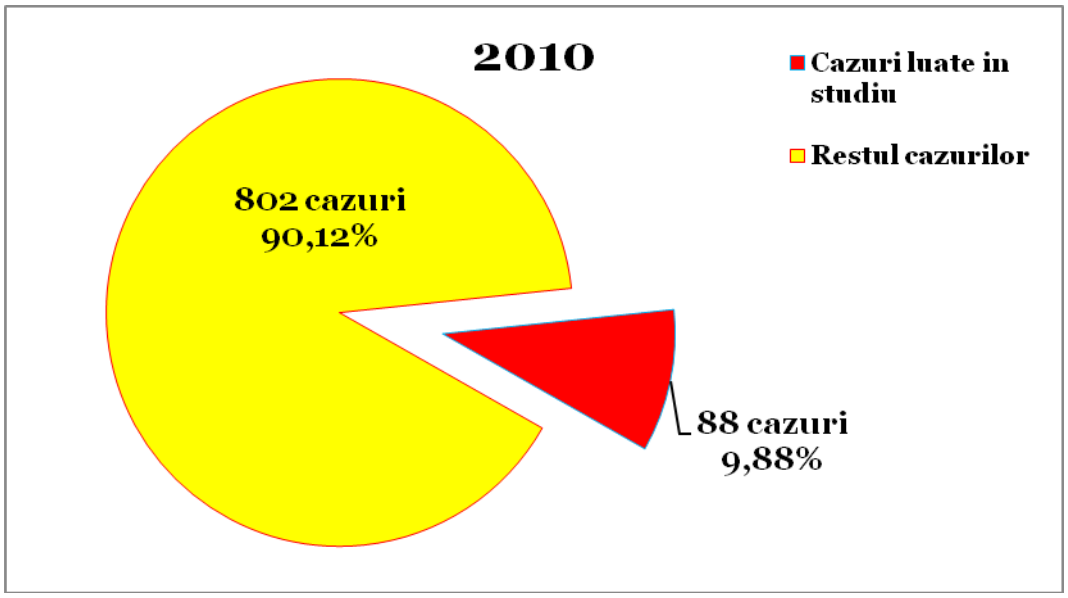

Fig.22. 2010 distribution of cases in the study group

* 2011 No. total 931 cases / instances lot 95 / -procent 10.21%;

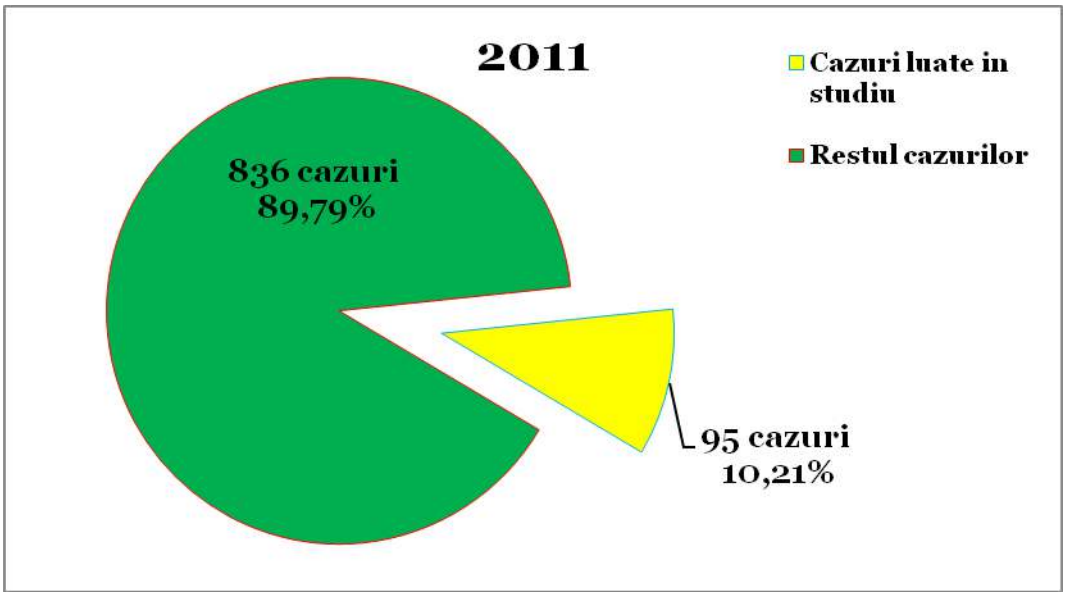

Fig.23. Distribution of 2011 cases in the study group

* Distribution of 2011 cases in the study group

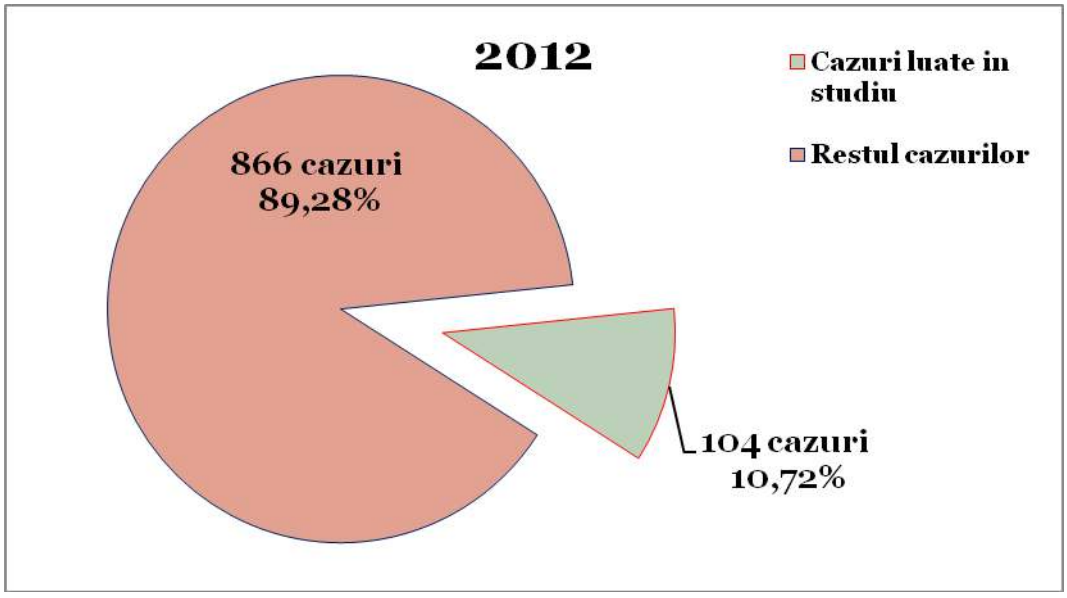

Fig.24. Distribution of 2011 cases in the study group

* 2013 nr.total 1359 cases / instances 127th batch 9.35% percentage;

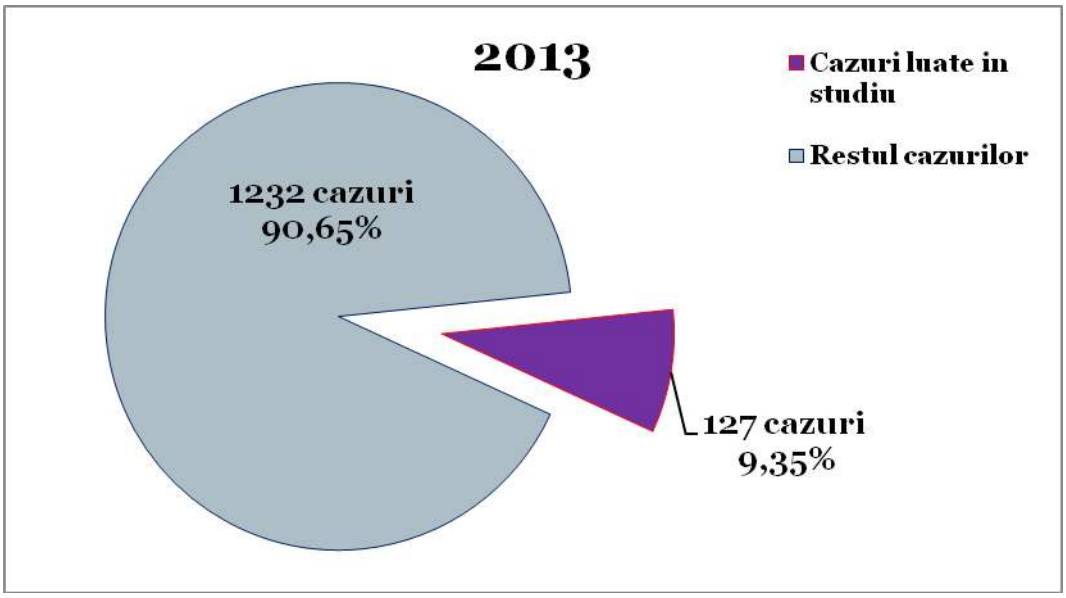

Fig.25. Distribution of the 2013 cases in the study group

* 2014 nr.total 1101 cases / instances lot 170-percentage 15.44%.

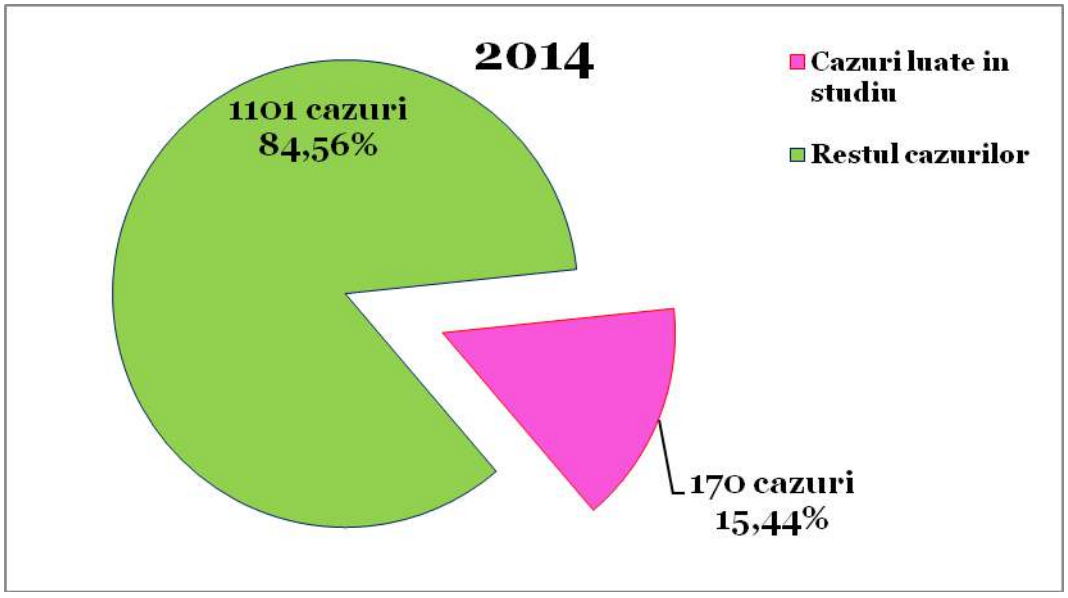

Fig.26. Distribution of the 2014 cases in the study group

While in absolute terms the total number of study group in 2014 is almost double the 2010 ie 170 cases compared to 88 cases it appears that the percentage (of the total number of patients in inpatient service) growth is not equally important but there are increasing every year and is a creşterte actual percentage (between 2010 and 2014) of 78.13%.

Increasing both the numbers (in absolute terms) and the percentage of cases that has become a process of reconstruction tissue defects of the face can be explained by the fact that the population, while realized the risks they run if they neglect various injuries facial skin and presents with conştinciozitate doctor and earlier periods and solving simple surgical wound becomes - excision and direct suture.

It should be stressed that the Clinic for Plastic Surgery and Reconstructive Microsurgery of Hospital Constanta County Emergency shown for specialized treatment patients from a population of about 500 000 inhabitants in Constanta County and neighboring counties and bear in mind that Much of simple injuries have been solved in other health establishments or dermatologists and surgeons either of these latter cases anyway did not qualify to be included in the study group.

In terms of etiologic defects skin / tissue of the face which imposed a reconstruction procedure has the following calendar year distribution:
* year 2010-88 batch cases: 85 cases postincizionale cases traumatic 1caz other

causes;

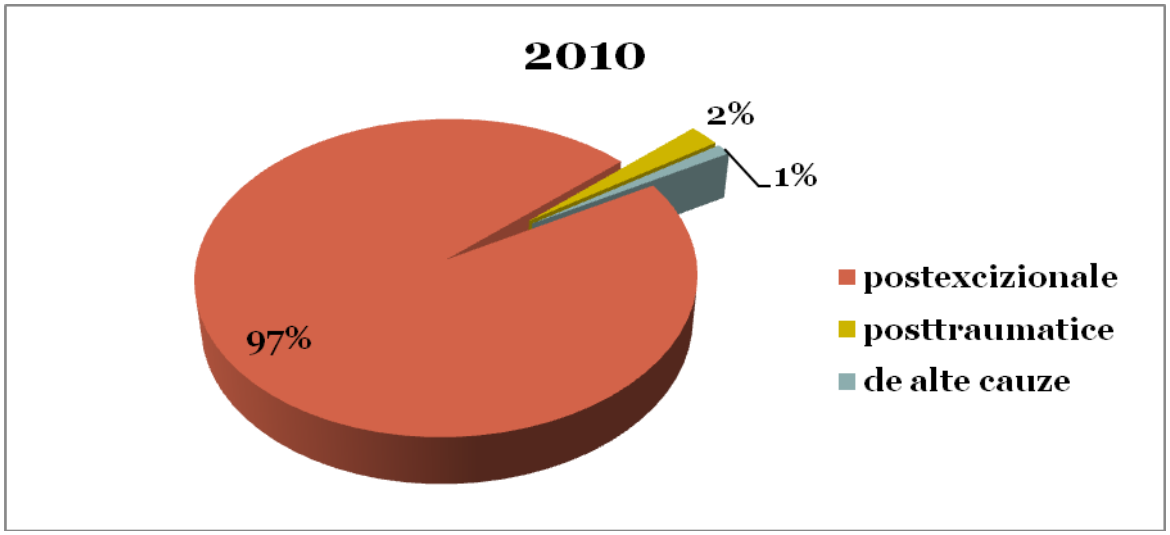

Fig.27. The distribution of cases in the study group etiology 2010

* 2011 year 95 cases in Lot 94 postincizionale cases, 1 case after plague geranium;

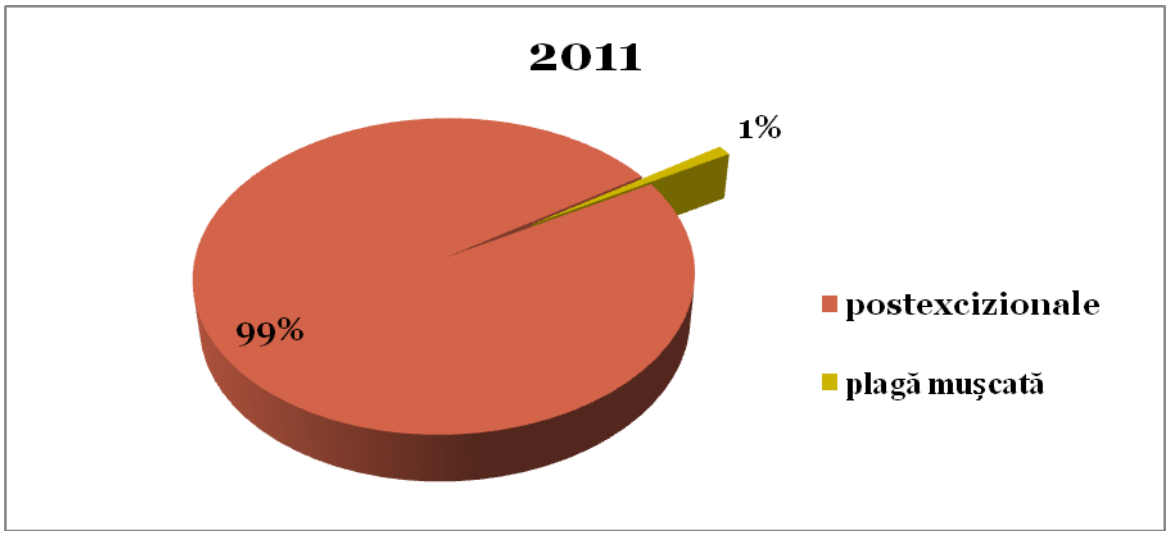

Fig.28. The distribution of cases in the study group etiology 2011

* year 2012 - 104 cases in Lot: 101 cases postincizionale cases traumatic 1caz other

causes;

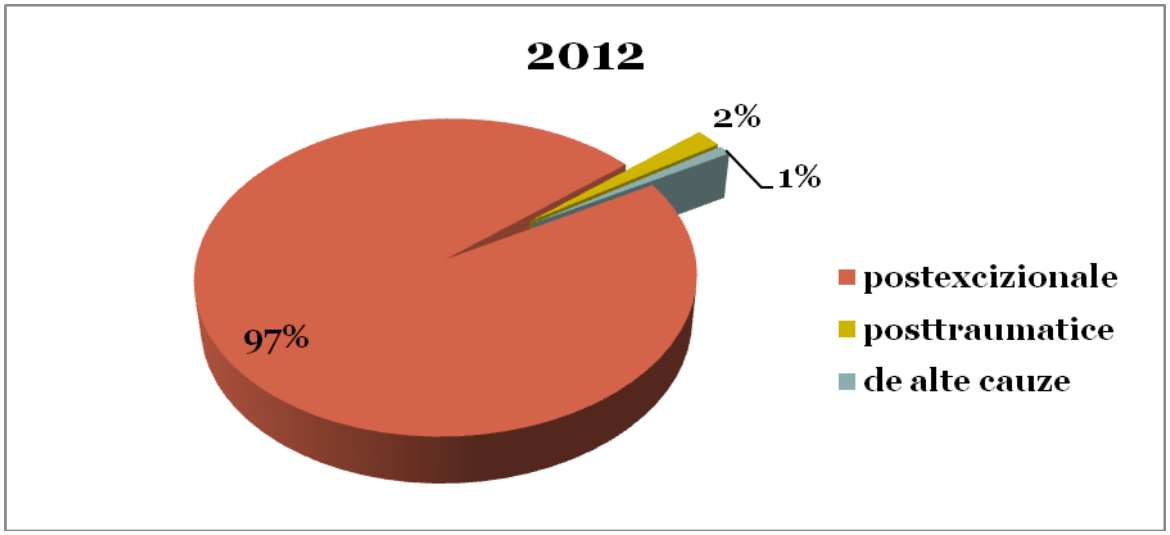

Fig.29. The distribution of cases in the study group etiology 2012

* Year 2013 - 127 cases in Lot: 123 postincizionale cases, 3 cases of traumatic 1caz after bite;

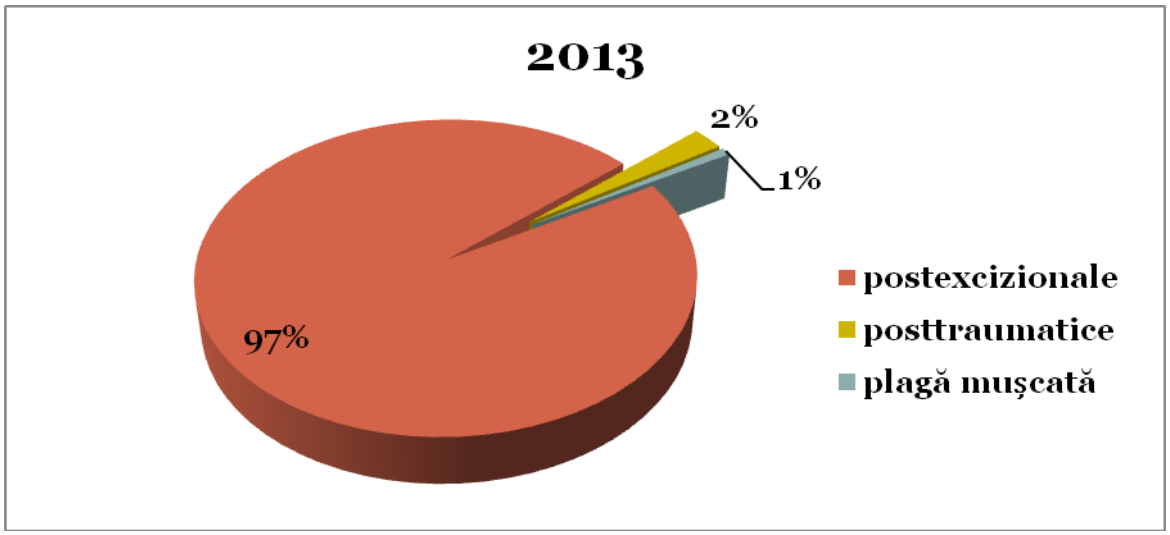

Fig.30. Etiology distribution of cases in the study group in 2013

* year 2014 - 170 cases in Lot: 167 cases postincizionale, posttraumatic cases, one other

cause.

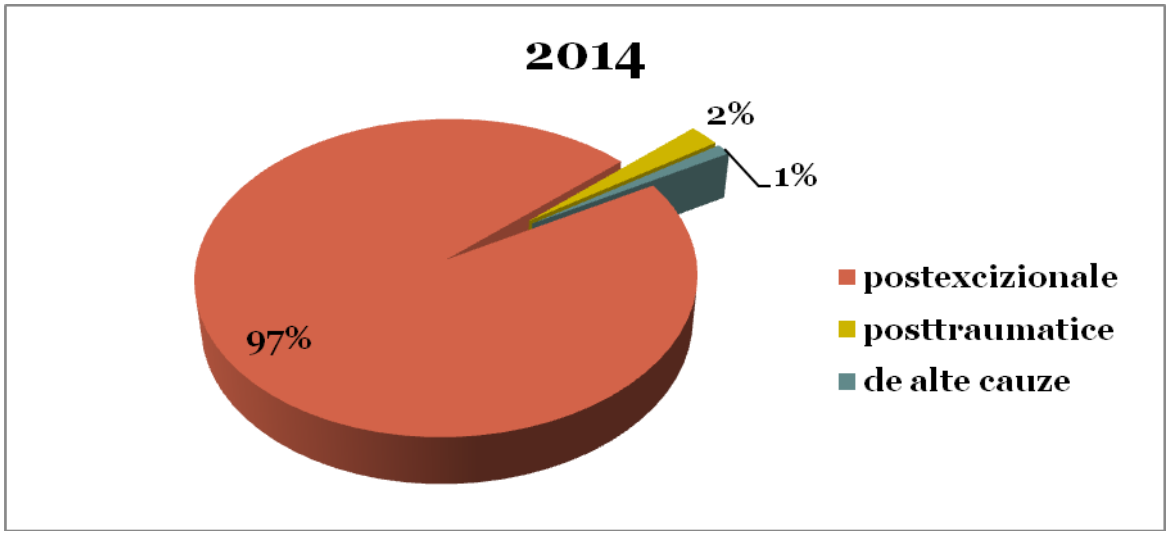

Fig.31. * year 2014 - 170 cases in Lot: 167 cases postincizionale, posttraumatic cases, one other cause.

From the statistical point of view it is clear that in an overwhelming proportion cases in the study group were the cause of the defect of skin / tissue of the face a tumors - etiology postexcizională - after which prevails and perform a surgical procedure reconstruction.

This etiologic distribution should concern both the medical and sensitize the population and because tumors in general, but also of the face shown in the last decade proving their aggressiveness multiple features:

-increasing the number of recurrence and / or metastasis

percentage decreases appearance of age;

-complexitatea therapeutic procedures (surgical) of radicalism increasingly complex and

major social Impacts they have these locations on the patient and his family.

Hereditary not be neglected aspect of tumor etiology because in most cases there is an inherited predisposition for the development of skin tumors heritage in the context of the overall appearance of the skin.

In all of the above must be added the general environmental appearance caused by natural radiation in planetary growth (it is aggressive natural radiation - harmful) and radiation induced social and economic development which is in a true expansion.

The etiology traumatic wounds or bites that after other etiologies maintained at values substantially the same throughout the study and did not lead to many medical and social implications as occurs when tumor etiology.

In terms of gender distribution of a total of 584 cases of the study group, in absolute figures, 339 cases were women and 245 were men which is, percentage speaking 58% women and 42% men

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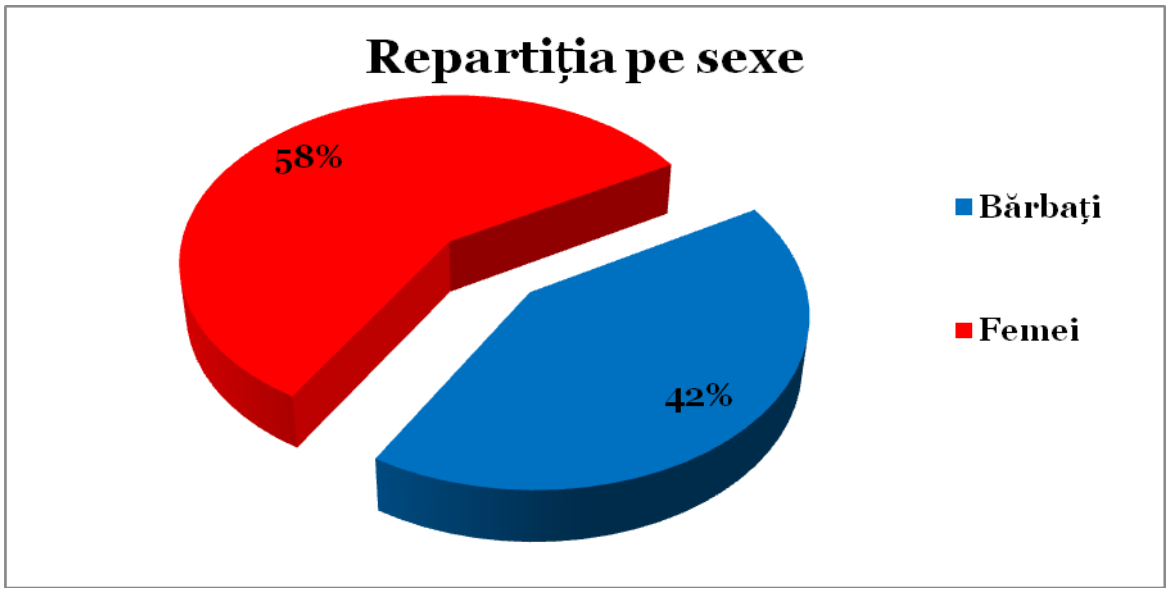

Fig.32. Gender distribution of cases in the study group

The high percentage of women in the study group can be explained both by the fact that they are more concerned with their physical appearance and therefore more conscientious and presented soon to the doctor or by the fact that the constitutionally skin female sex is more fragile (thinner) and therefore may suffer faster changes under the influence of aggressive environment.

Details of this study are part of the general trend in the data presented by other studies published in the literature differences between them being within 1 -2 percent.

There are theories that claim that cosmetic procedures order that women are more often subject can contribute a small percentage increase in cases that develop skin lesions of the face.

Returning to the etiology postexcizionale tissue defects of the face on the study group found that tumor etiology is definitely majority and in percentage is as follows:

* year 2010 to 96.51% of tumor etiology

* year 2011 to 98.94% of tumor etiology

* year 2012 to 97.11% of tumor etiology

* year 2013 to 96.85% of tumor etiology

* year 2014 to 98.25% of tumor

etiology.

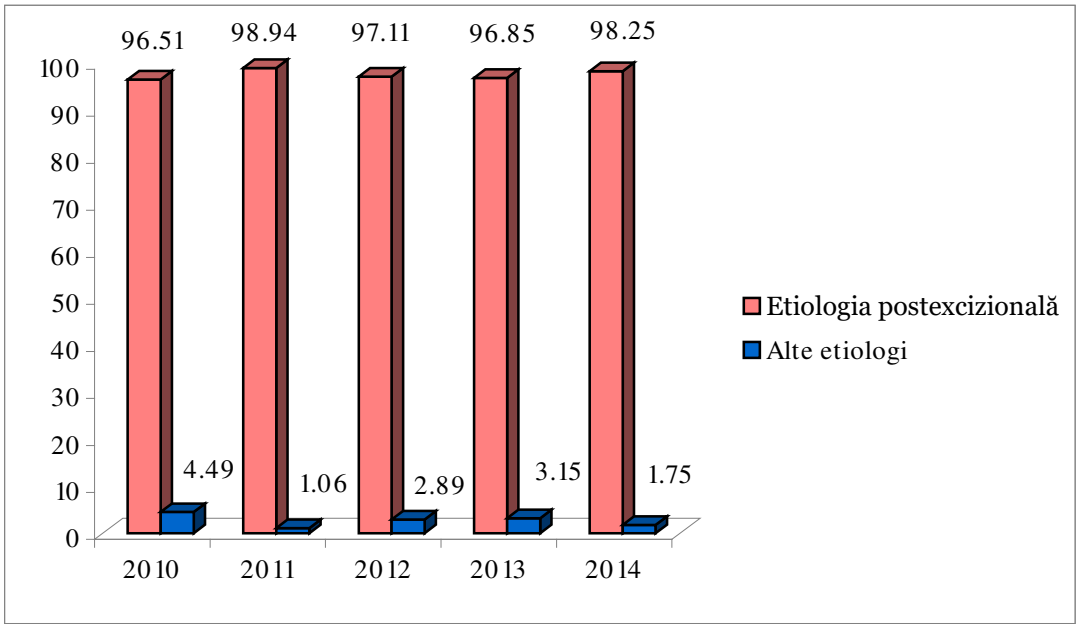

Fig.33. Etiological distribution of cases in the study group

It appears, therefore, that in none of the years under study share etiologic tumor defect tissues of the face has not fallen below 96% and in 2011 reached almost 99% and it should be noted once again that the study included only cases in which the defect postexcizional exceeded 2 cm2 and only when the defect was imposed to cover a surgical reconstruction procedure.

To APEC breakdown by age of the cases studied we resorted to carving age of the patients in three age groups: 18 -40 years; 41 -60 years; 61-92 years.

The entire group of patients was distributed as determined by age group;

* 18 - 40 years - 89 cases;

* 41 -60 years - 389 cases

* 61-92 years - 106

cases.

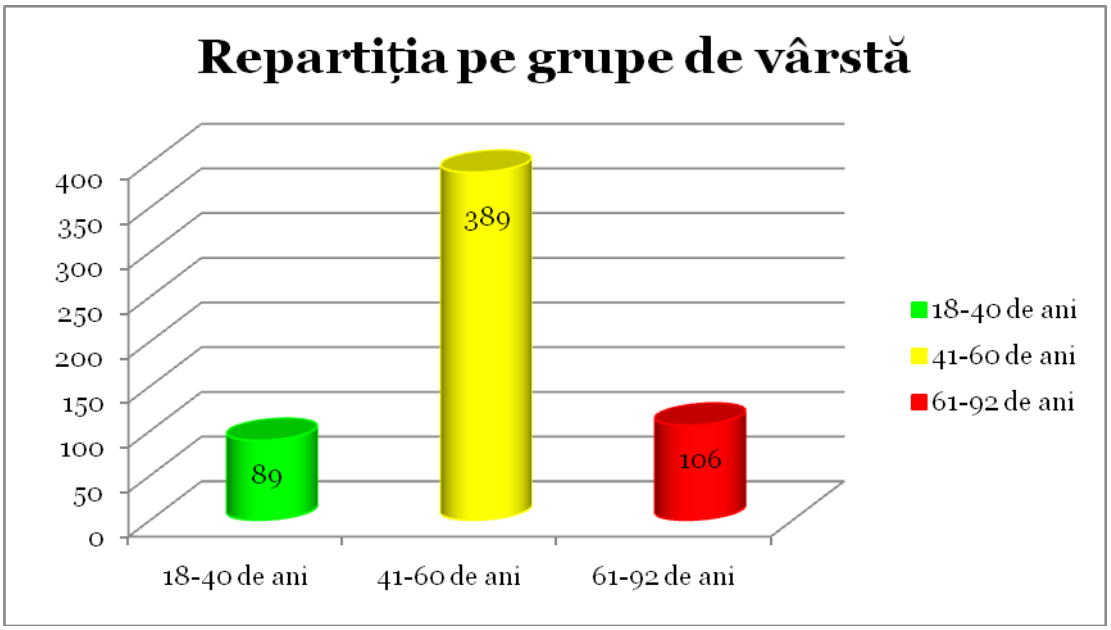

Fig.34. The distribution by age in absolute numbers

The study shows that the percentage was distributed mostly in the age group 41-60 years respectively 66.60%, followed by the age group 61-92 years with a percentage of 18.15% and lastly age group 18-40 years with a percentage of 15.25%.

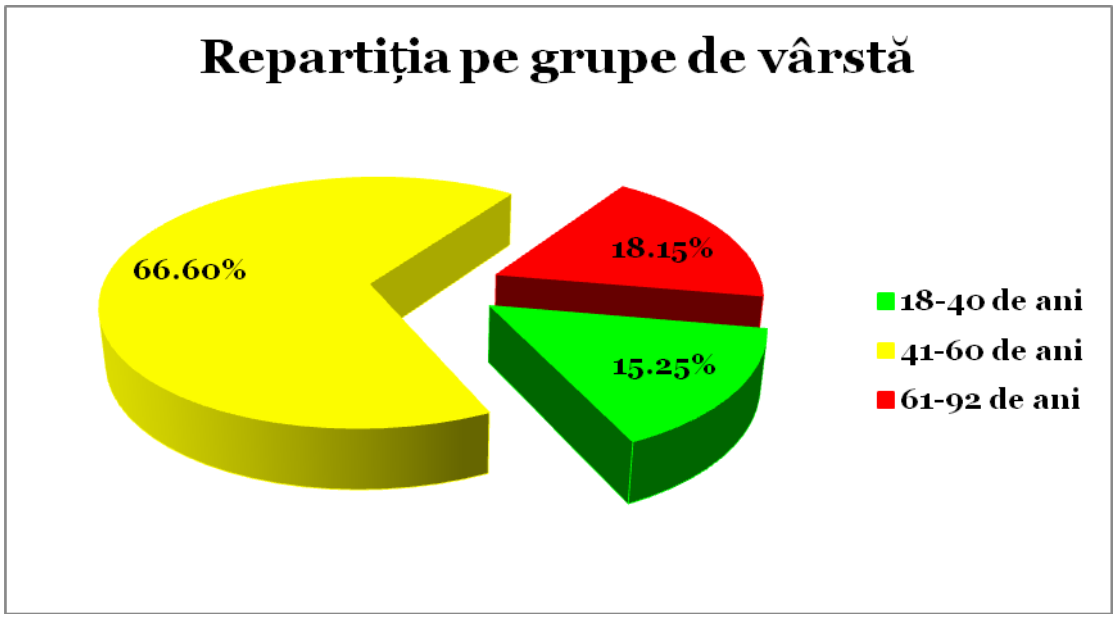

Fig.35. Percentage distribution by age

The age distribution in the finding Shows That group 41-60 years of age is most often Corresponding to the age of the most active among; Population and CAN have negative repercussions this faction Influencing work capacity and Hencse rise in the number of the days of incapacity for work on medical Grounds.

But Takes distribution by age and calendar years with full state corporation We Can That each year the number of cases studied for 18-40 years group showing increases Clearly Continuously working vârsăa That malignant tumor formations The Age appearance of the make is decreasing (occurring in Younger and Younger ages).

* 2010 group 18-40 years - five cases - 5.61%;

* 2011 group 18-40 years - eight cases - 8.98%;

* 2012 group 18-40 years - 13 cases - 14.60%

* 2013 group 18-40 years - 29 cases - 32.58%

* 2014 group 18-40 years - 34 cases - 38.20%.

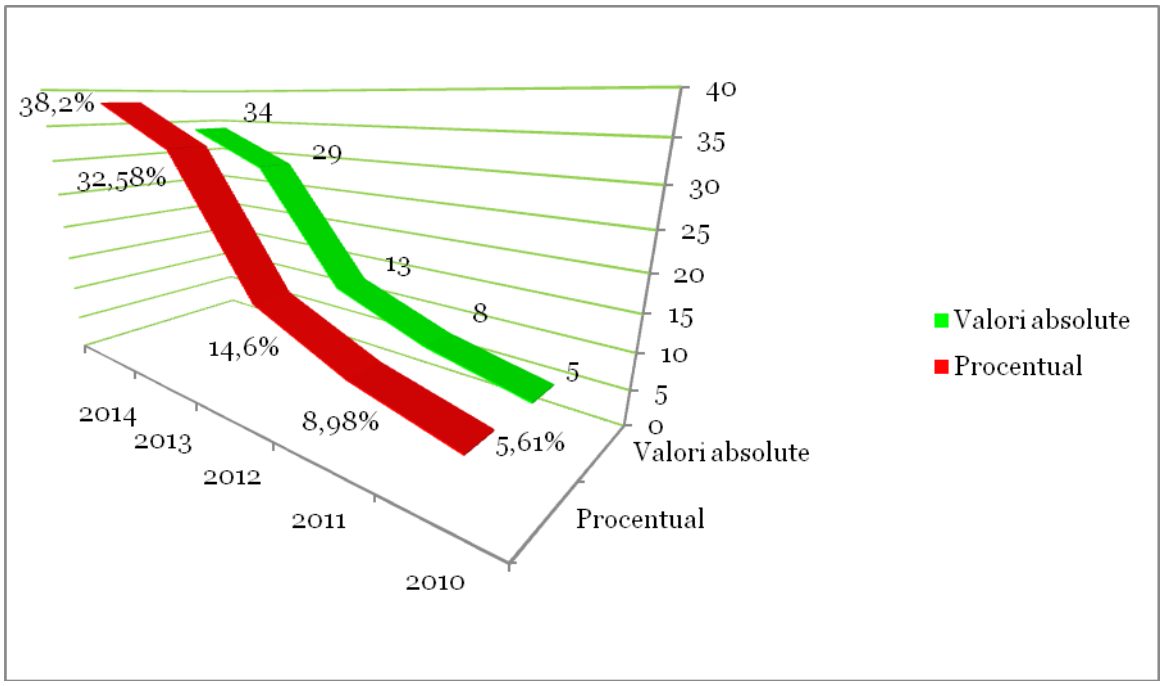

Fig.36. The increasing incidence of tumor formation in the face during the study age group 18-40 years in the study group

In absolute numbers we can see that within 5 years the number of cases study in the age group 18-40 years increased, in absolute numbers of about 7 times as a percentage of the total number of cases is increasing lot 7 times that of 5.61% to 38.20%.

For age groups 41-60 years and 61-92 years cases by calendar year percentages remain relatively constant with a slight increase, with no significant age group 61-92 years which may be explained by increased life expectancy recorded in this time.

To determine whether there is a link between the area of origin of patients - urban or rural - proceeded to repartiţa lot on both social media and found

that in all age groups and throughout the study period there was a predominance of cases in urban environment Statistically significant differences by age and calendar years.

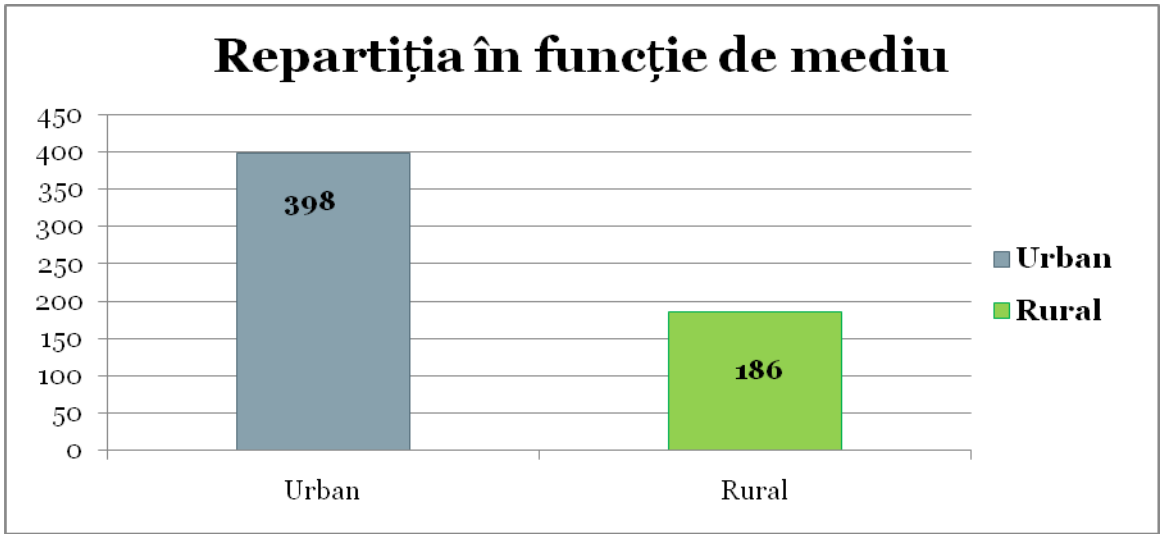

Fig.37. The distribution by area of origin in absolute

In percentage terms we so a figure of 68.15% of the urban and rural 31,85%.

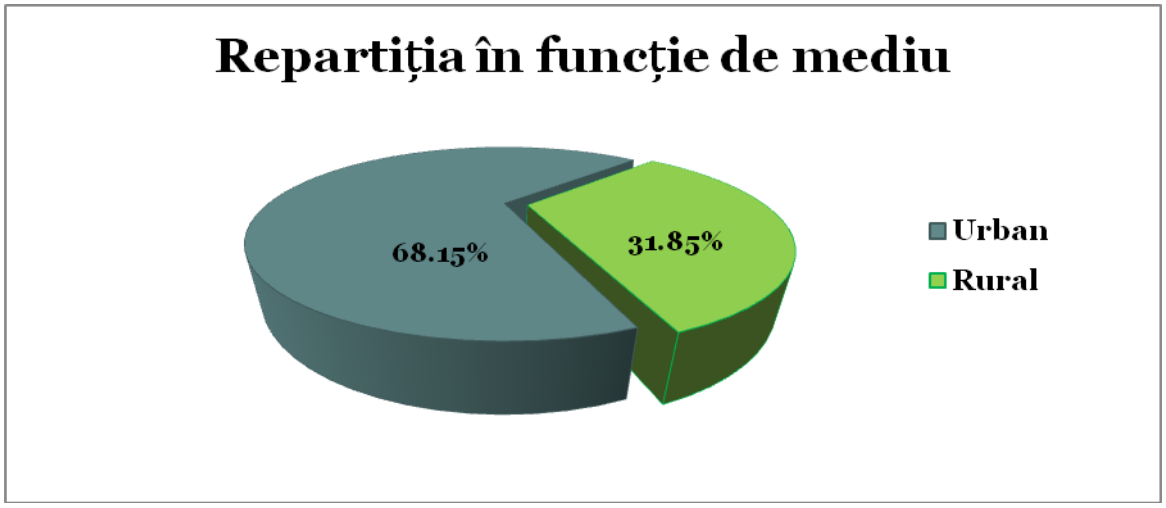

Fig.38. The distribution by area of origin percentage

The figures observed can be explained by the fact that patients in urban areas have better access to specialized care, they may have a higher education degree in fine health and are more concerned about their physical appearance (facial appearance).

We should not overlook the fact that in rural areas may have a higher exposure to solar radiation (those working in agriculture), but that those in urban areas are subjected to much more favorable cases.

A noted clinical observation without quantified statistically related to the area of origin of pacienăţilor defective postexcizionale the face that required a process reconstructive surgery is that patients in rural areas presents consultants in stages more advanced development of tumors and used (sometimes years) before empiric treatment expert advice which is usually the dermatologist.

To see the practical value of each method used in the study group were classified reconstructive surgery purpose into 4 major categories namely:

Direct -sutura after takeoff prior to excision margins with a total of 73 cases;

-acoperirea facial tissue defects with autologous free skin postexcizional split with a total of 95 cases

-acoperirea postexcizional defect using autologous full thickness free skin with a total of 182 cases

-acoperirea postexcizional facial defects by using a tissue flap locoregional with a number of 234 cases from the total of 584 cases taken in the study group.

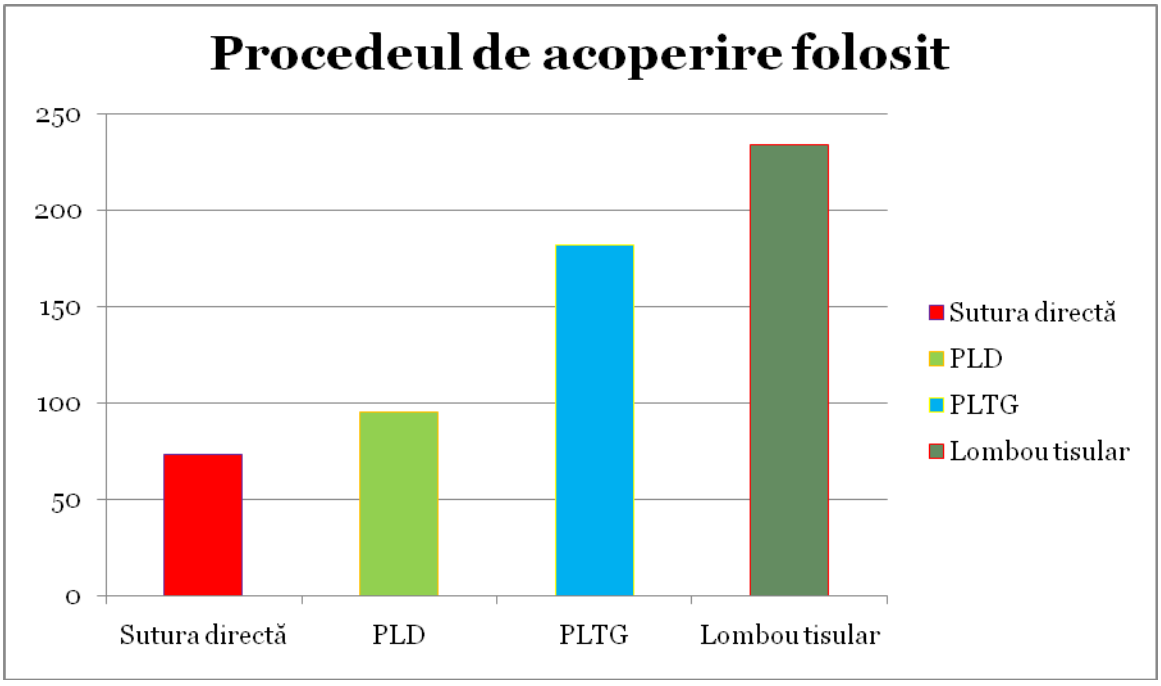

Fig.39. Distribution of cases depending on the coating process used

Translated percentage situation is as follows:

-scutură after takeoff prior to a percentage of 12.51%;

-palstie free skin split 16.26%

31.16% full thickness skin

-plast and regional coverage -lambouri 40.06%.

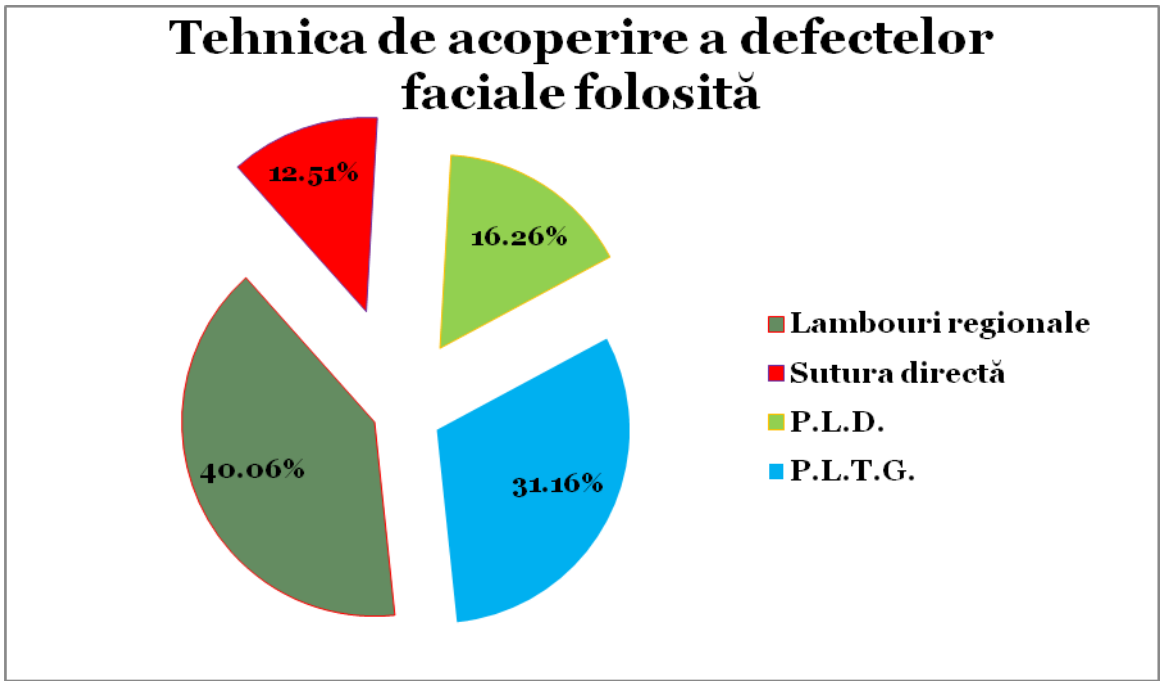

Fig.40. The percentage of coating techniques used for facial tissue defects

t should be noted once again that these reconstructive procedures were initiated clinical study that aimed to see the value of non microsurgical reconstruction processes defecterlor tissue / skin of the face.

It may be noted that the largest share regarding reconstruction procedure have used a regional flaps which can be clinical anatomic justicficat by the following:

The girl having a very rich vascularity allows cutting the infinite number of local flaps coverage - the so-called flaps on the random movement;

-By aesthetic value and social front should have quality material reconstruction of the highest quality and from this point of view is ideal tissue at regional and

-By its structure and tissue laxity (excepting the lower 2/3 of the nasal pyramid) before enabling the plastic surgeon to adapt a multitude of regional flaps cover actual needs.

The indication of fault coverage with free skin autologous split was dictated by a number of factors such as:

-defecte skin / tissue surface exceeding 40-50 cm 2 and tumor formations are the result of intricate local excision (sores, infected, bleeding) and

-existence of associated diseases that do not give guarantee evolutionary success using locoregional flaps (uncompensated diabetes) and / or extend the time of surgery under general anesthesia.

There is also a practical argument for using free autologous skin (split or full thickness) given that after extensive excision of tumors can follow any recurrence DEAT easier when hen postexcizional defect was covered with a flap locoregional.

Plastic free skin full thickness harvested from areas of choice (BTE, front arm) represents a valuable and easy coverage of tissue defects facial especially when we face cases in which the excision of local recurrence (which are, as a rule, after prior maneuvers skin).

The advantages of full thickness skin plasty are:

-Ensures cosmetic results good order (depending on the area where used);

-allows tracking "through a glass" of possible local recurrences marginal and

-Data is reduced to not induce deformations retractibilitatea late locoregional and maintains also a color quality.

Marginilior their suture defect after takeoff prior - where the anatomical structure permitting - is the solution used in a percentage of 12.51% of cases the study group and it can be used only when the defect hen has postexcizional between the two sides following being sutured 3-4 cm in size.

Judging theoretical things we can say that in such a situation we are dealing, in fact, advancing towards the center of the fault has two flaps facing each other and for suture look and well in cosmetically will determine preoperatively suture line direction so that it can address two key issues:

-sutura final suture lines comply with the minimum voltage lines and faces known surgery

-excizia to transform drawing safety margin oncology in one area of one circular elliptical in order to improve the quality cosmetics suture.

Compared to other studies published in the literature on tissue defects facial and methods of reconstruction of their present study falls as data obtained their limit but appreciate that worked extremely important that this study it highlights is that age who develop facial tumor formations requiring local reconstruction (in the age group 18-40 years) increases every year reaching almost disturbing as the 5 years that this study lasted approximately 6 times increase in absolute numbers.

This comes to draw the attention of the medical world on a key element that represents health education which is extremely important to use

without reluctance or reservations subjective winnings scientific and technical field, and I refer here specifically to dermoscopy.

Dermatoscops besides the utility already proven correct diagnosis preoperatively may be useful as a method of tracking preventative of tumor formations pigmentation on the face and even follow postoperative for damage relapses and, why not, could be useful as a method screening.

In respect of the credibility that the Clinic of Plastic Surgery and Microsurgery in Hospital Constanta County Emergency attaches dermatoscopiei digital should be noted that patients last 2 years of the study group (for the years 2013 and 2014 - in absolute numbers 297 cases) received full examination for diagnosis and therapeutic dermoscopy.

We should not omit the fact that some patients have benefited from the years 2010 -2012 performing dermoscopy examination so that it can be said that a percentage of 65% of patients in group benefited Dermatoscops pre-surgical examination - in absolute numbers 381 patients and the percentage 65.23%.

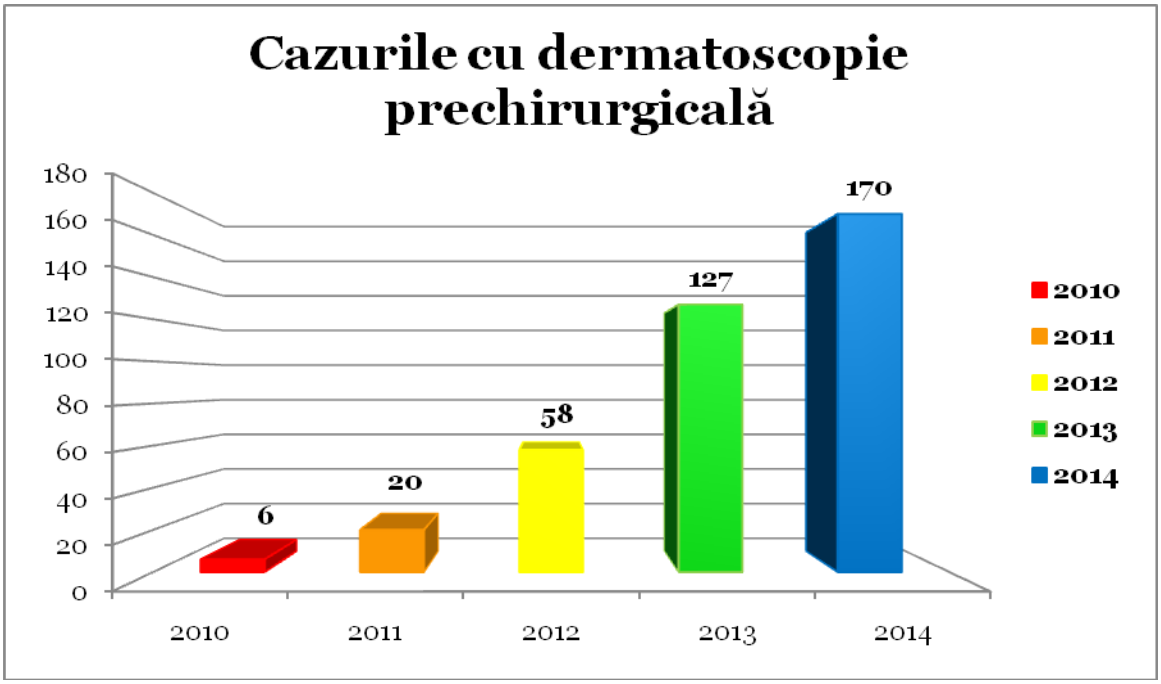

Fig.41. The yearly distribution of cases that benefited from dermoscopy examination.

Clinical research has included a critical study of the complaints raised by patients pantru first presentation to see a specialist in order to solve the problems they were accusing.

From this point of view we tried to establish what time has elapsed since the onset of the disease to consult the specilalitate and unfortunately a rather high percentage of patients ie 72.6% of the study group elapsed time was than 1 year of disease onset.

It stressed that all patients have "benefited" local empiric treatment or specialist dermatology at least 4 to 6 months before surgical solving - ie before admission to the Clinic for Plastic Surgery and Reconstructive Microsurgery Constanta County Emergency Hospital.

Another 20.45% percentage of patients that were hospitalized after the preralabil, were examined by the family doctor and dermatologist 1-2 months

ago that indicated a solution checkups surgical excision histopathological examination piece to establish comprehensive and complex therapeutic attitude.

Only a percentage of 7.95% of the study group patients were hospitalized and treated in the clinic after previously were presented at a medical (usually the dermatologist) on preventive considerations and further checkups Primary was found and called for the radical treatment of injuries.

In the latter situation is găesc patients whose pathological lesions evolve preexisting lesions in patients being monitored Evolution (most often personal initiative) of at least 2 years; these patients could benefit from the simple surgical procedures to cure.

As to the anamnesis I found that motivation seeing the doctor (family, dermatologist or plastic surgeon) was one aesthetic meaning that injuries that were evolving in the face prejudice from this point of view - in our group a percentage of 83.40% - this highlights once again the importance that before (his appearance) in defining physiognomy.

A percentage of 12.51% of the patients in our study were motivated first presentation at a medical to concerns about further development of lesions on the face of noting small changes preexisting lesions.

It stressed that a percentage of 8.09% of patients in group were presented at the first health professional to urge insistence and even family or close entourage decision, a remark must obviously be made for this latter group of patients in that he consists mostly of elderly patients who do not have special concerns regarding the appearance or younger are men with a low cultural level.

Research lot this patient revealed that all subsequent empirical treatment for at least 1 year prior to medical examination of primary and accepted with reluctance verdict medically established that we face a malignant lesions (it is the group represented by the 8 , 09% of patients).

It should be noted that a significant proportion of this population bears multiple loud general thing that can explain the neglect of tumor lesions facial although it evolves unfavorably (that is patients with sequelae after stroke, respiratory failure and cardiac within bronhopenumopatiei Chronic obstructive or valvular heart disease, uncompensated diabetes mellitus and chronic renal failure in dialysis-dependent).

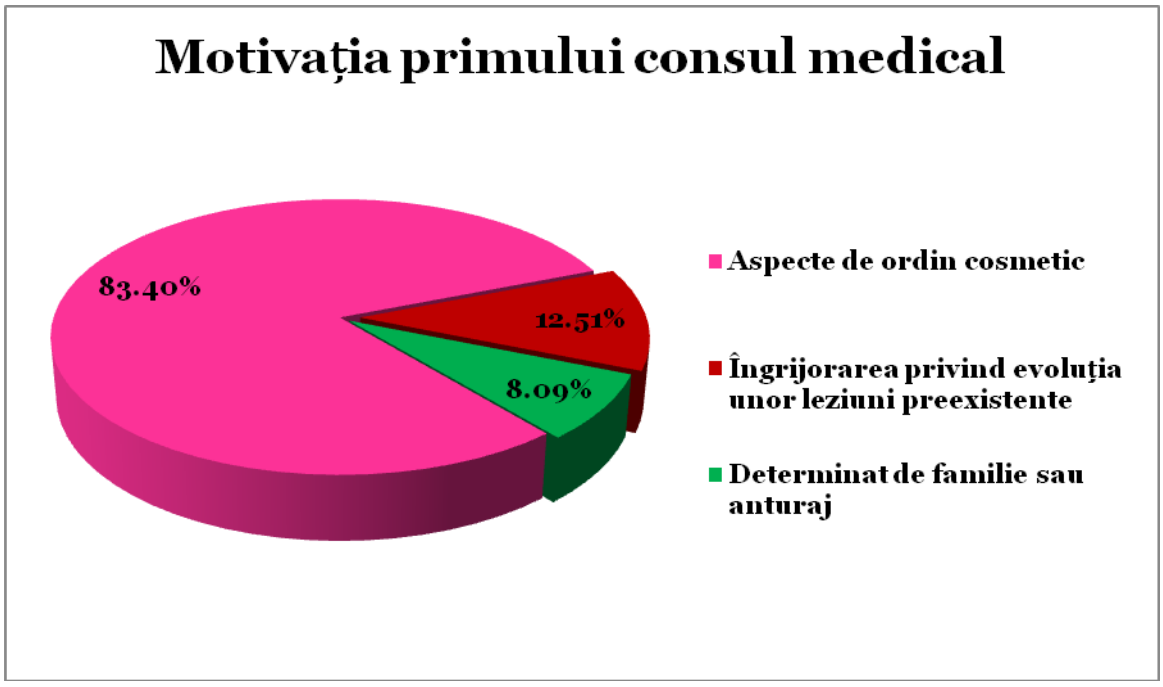

Fig.42. Distribution of motivation presenting the first medical checkup

Another spec researched group of patients was related to how patients were chosen doctor who trusted to solve problems and found that a very high percentage of patients have chosen physician taking into account the

references obtained from family or entourage as the reputation which enjoys local doctor (a percentage of 87.64%) and only a percentage of 12.36% had no choice criterion physician.

A high number of patients who had criteria in choosing the treating physician - 87.64% group - were influenced by the doctor who gave them first checkup or medical personnel in his entourage but most had as a criterion the doctor's professional

reputation.

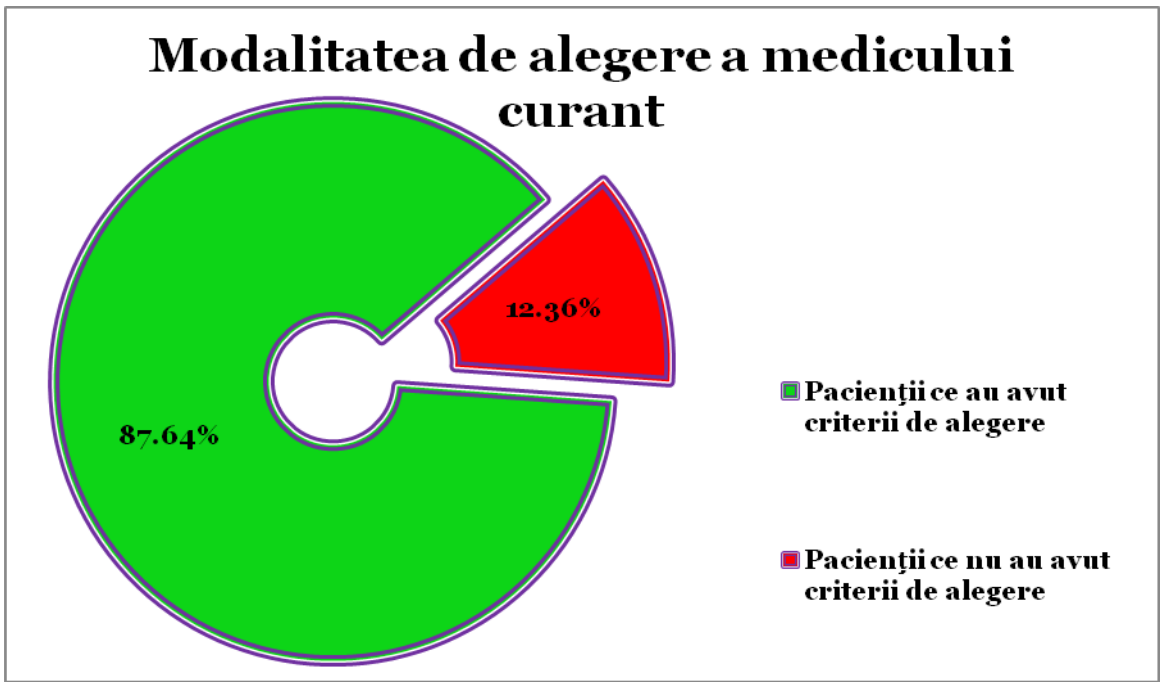

Fig.43. Election procedures treating physician

Some patients study group that 183 cases (casuistry related to calendar years 2010 and 2011) were interviewed (based on an anonymous questionnaire) about the satisfaction that I had at 6 and 12 months compared to the result treatment of aesthetic and functional point of view.

Cercetarera showed that a total of 159 patients were very satisfied with the result, a total of 17 patients were satisfied and only one of the 7 patients were partially satisfied what percentage is shown in the figure below.

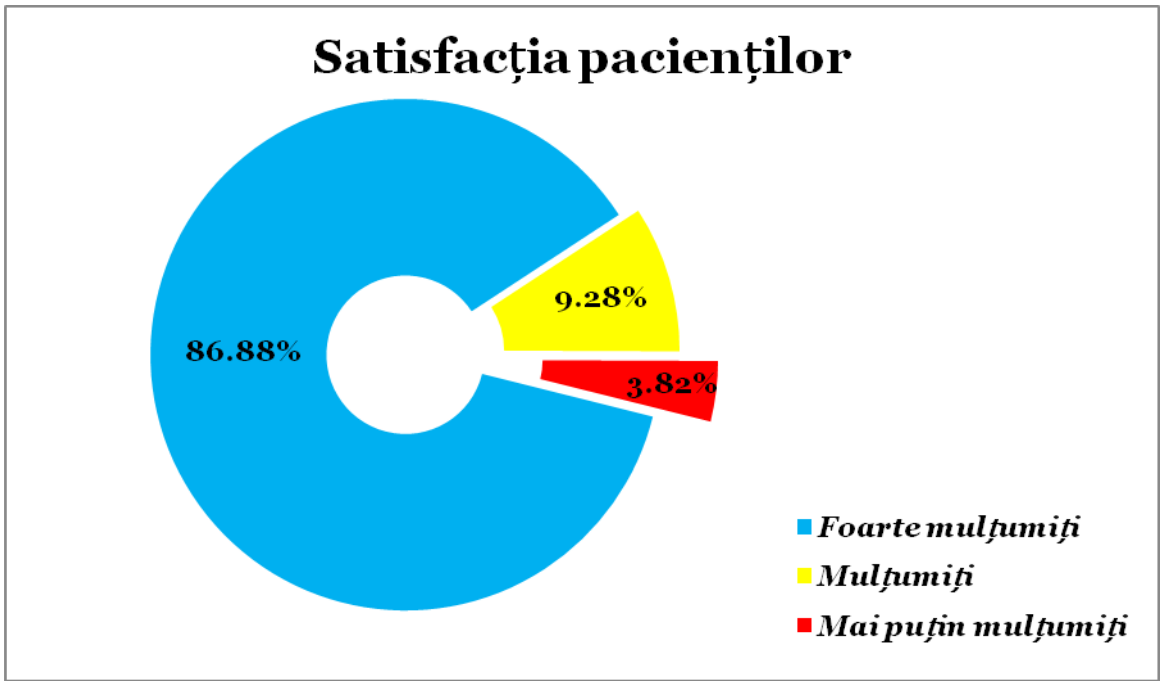

Fig.44. Reprezentarea grafică a procentului de satisfacţie a pacienţilor

In trying to analyze the results of this questionnaire can say that in general, patients had a high degree of satisfaction posttherapeutic and that only a proportion of about 4% (3.82%) were less satisfied and can say that this percentage is represented in the majority of patients present in advanced stages of the disease and the treatment modalities - surgery required sacrifices anatomical major local and sometimes even sacrifice order partial functional - the main goal of treatment is the the oncological radicality.

Conclusion

• In rebuilding coverage and facial tissue defects apply the basic principle of plastic surgery in the sense that it will opt for surgical procedures simple but effective although there are cases where a more complex process ensures a better functional and aesthetic result.

• The cover and reconstruction of the face prevails functional outcome although the facial appearance has a special importance (facies).

• Factors to consider when choosing the reconstruction procedure are:

-convenient lesion;

-Star local blood supply;

-This infection;

-extensia lesion excision;

-age of the patient;

- The patient's desire.

• The most important factor that can influence the choice of method reconstrcutive surgeon in the face is the location of tissue defects (facial aesthetic areas)

• There is a close connection between the aesthetic anatomy of the face area and the surgical method of coating and / or tissue reconstruction Fault.

• Choosing the right reconstructive method is as important as solving given that the correct surgical indication is medical thinking and its achievement depends on the ability of the surgeon.

• Assessment of surface and depth precise tumor (excision zone) is that which can decide coating method (reconstruction).

• radical excision of tumors is mandatory and the existence of multiple previous surgeries (recurring) complicates interventions excision and reconstructive vision may change.

• cutaneous tumor pathology is an important majority share - 97.53% in our study need coverage and reconstruction of facial tissue defects.

• Selecting the reconstructive surgeon makes only based on his professional experience and courage.

• Among the methods of local flaps covering facial defects in various forms (rotate, advanced translate) majority.

• The dermatoscopiei in skin tumors is not only diagnostic but also therapeutic (taking oncological excision margins) and dermoscopy diagnostic concordance in our study (digital dermoscopy) and histopathological is 98.60% even in terms of staging.

• Age 40 to 60 years from the cases studied group represented 66.60% of cases, followed by the age group 61 -92 years with a percentage of 18.15% and the age group 18 -40 years with a percentage of 15.25%.

• Today we are witnessing a revolution in the field of technical procedures covering surgical tissue defects (started in 1982) that the replacement of the use of free flaps transferred microsurgery (for operator time, the morbidity of the donor site) with flaps regional or local based artery perforator (material reconstruction of very good quality and avoid awkward assets).

• The main cause of facial tissue defects that require reconstruction procedure is the facial tumors - in the present study at a rate of 97.53% weighted average on the 5-year study.

• The flaps local and / or regional first choice for reconstruction of tissue defects facial having only drawback that there is a rapid pace of innovation of

new variants of flaps and therefore it requires an effort to adapt the surgeon to new techniques and stimulate so imagination.

• The incidence of defects postexcizionale for tumor lesions on the face of the alarming increase between 2010 and 2014 respectively 5 cases (5.61%) in 2010 to 34 cases (38.20%) in the age groups 18 -41 years ; growth of about 6 times !!!!!!!

• As a therapeutic process of reconstruction in the study group locoregional flaps were dominant with a share of 40.6% followed by full thickness free skin plasty with a percentage of 31.16% and free skin plasty with a percentage split of 16 26% and only a percentage of 12.51% opted for direct suture excision margins after takeoff and prior to their mobilization.