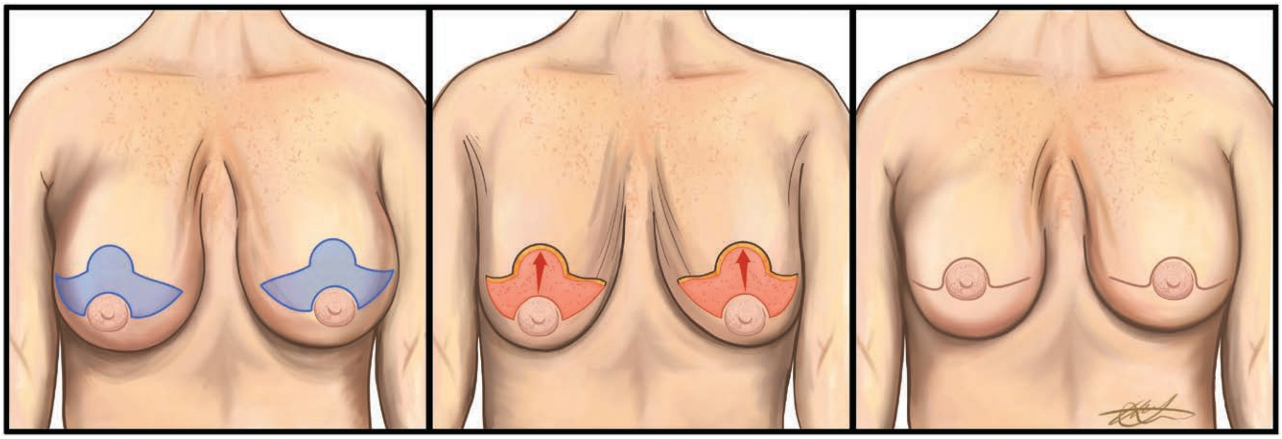

Fig. 1. (*Left*) Breast augmentation with Regnault grade II ptosis with markings for omega lift (*blue line*). (*Center*) After removal of breast implants by means of incision along the superior limb of the omega pattern. Removal of the breast implant reveals more severe ptosis and thinned soft-tissue envelopes similar to mastectomy flaps. Here, the skin inferior to the incision is deepithelialized and used to autoaugment the upper pole. Alternatively, the incision could be made along the inferior limb of the omega pattern (not shown) to allow the deepithelialized tissue to augment the nipple-areola complex. The nipple-areola complex will be repositioned with the skin closure, as shown by the *arrow*. (*Right*) Final closure with correction of ptosis and an omega-shaped scar.

augmentation. For those patients with prior subglandular augmentation with atrophic glandular tissue and thin ptotic skin envelopes, it is our experience that the omega lift yields a safe and aesthetic result.

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Anatomy of Flank Adipose: The Y Configuration and Hip Extension and Their Effects on the Perception of Gender

A circumferential approach is increasingly used for body contouring procedures.[1] To that end, surgical reduction of all flank adiposity can improve the quality of results. We are reporting a new anatomical finding that has the potential to further improve outcomes and gender-specificity of results. The anatomical configuration of flank ("love handle") fat and its gender differences have been inadequately described. At best, reports mention the presence of a single "roll" wrapping laterally and anteriorly from the paraspinal region[2] or a "lower thoracic roll" in patients after massive weight loss.[3]

We documented flank adiposity using pinch-testing and topographic mapping before liposuction. Standardized photographs at 45-degree increments were de-identified and analyzed in 40 consecutive women and 48 consecutive men presenting for primary liposuction. We excluded patients needing revision, requiring skin excision, or exhibiting human immunodeficiency virus lipodystrophy. One surgeon (D.T.) created contour maps using indelible ink at 1-cm increments of pinch-thickness above baseline. Standardized

Fig. 1. Y-shaped flank adiposity was found in all study subjects. (*Left*) A female patient with large flanks and no hip fullness is perceived as masculine. Note that she also has no lateral thigh fat, further masculinizing her shape. (*Right*) A male patient is perceived as feminine in shape, with less flank volume than many men in the presence of large hip extensions. Note that he also exhibits fullness of lateral and medial thighs, further feminizing his body form.

images[4] of posterior and posterooblique views were deidentified. A second surgeon (J.B.) evaluated photographs of the mapped flank adipose. A third nonauthor surgeon confirmed that analysis parameters were met and anatomy in the photographs matched recorded data. Appearance of gender (having feminine and/or masculine features) was made independently by all three image reviewers, based on whether subjects exhibited postpubertal contours seen in the average XX or XY individuals in the general population and is reported below, with all three reviewers in agreement.

Topographic mapping showed bilateral, horizontally oriented, Y configurations of flank fat in 100 percent of subjects, as shown in Figure 1. Consistent anatomical findings included the following: (1) the upper limb originated lateral to the midline near T11, enlarging as it wrapped inferolaterally; (2) the lower limb originated near L3, and traversed the lower back horizontally; (3) these branches coalesced into the stem of the Y, which wrapped anteriorly; (4) maximal fullness occurred at the posterior axillary line; (5) the now-singular "roll" continued anteriorly, terminating near the anterior border of the external oblique muscle; and (6) the upper limb of the Y invariably pointed toward the contralateral scapular tip.

All subjects, including the leanest, had Y-shaped flank fat. In women, maximum pinch thickness was similar to or less than that of men (average, 3.4 cm in men and 3.3 cm in women), despite higher body mass index values, suggesting that fullness is less in women when controlling for body mass index. Thickness of hip fat varied widely. Thirty-six of 40 women (90.0 percent) appeared visually feminine, with 32 (88.9 percent) having fullness of hip fat extending inferiorly from the stem of the Y near the posterior axillary line. Four women were lean and without hip fat but appeared feminine because of flare of the underlying pelvis. The remaining four women were visually masculine, having neither hip extensions nor pelvic flare (Fig. 1, *left*). Eighteen of 48 men (37.5 percent) demonstrated feminine truncal appearance. Of these, 16 (88.9 percent) had fullness extending over the hip (Fig. 1, *right*). Importantly, absence of hip fullness with presence of thick Y-shaped flanks was consistently perceived as masculine, regardless of gender.

We conclude that Y-shaped flank fat represents normal human anatomy. When present, hip fullness created the perception of feminine form, regardless of gender. To further refine the "zone of adherence" concept, hip fullness shifts the apparent location of concavity to a more focal and inferior locus[5] regardless of gender.

Clinically, liposuction of all fullness from the stem and both limbs of the Y optimized outcomes in both genders. Finally, evaluation for the presence of hip extensions permitted gender-specific surgical planning. Unfortunately, iatrogenic feminization of men occurs when flank reduction is performed without or with inadequate removal of hip fullness. However, near-total reduction of unwanted hip volume in men permits consistent, intentional masculinization. Autologous fat transfer into the hips consistently feminizes the waist, regardless of birth gender. Therefore, attention to focal fat pad anatomy has the potential to create gender-specific outcomes, allowing inborn gender identities to better match socially perceived body shapes in *all* patients.

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What Is the Effect of Different Costal Cartilage Carving Methods on Warping during Rhinoplasty?

Surgeons who perform revision rhinoplasties or augmentation rhinoplasties usually use homografts (especially rib cartilage), which have a disadvantage of warping.[1] The most exciting article in the past years about rib warping was from Taştan et al.,[2] named the oblique split method.[2] We planned a study to determine the effect on warping of rib cartilage cuts in different directions in an experimental bovine rib model.

This study was a cadaveric bovine study. The ribs were cut in four different directions (i.e., oblique, reverse oblique, horizontal, and vertical) like a spreader graft immediately after slaughter. A total of four groups were formed, with 10 cartilages in each group. Each cartilage was 2 cm long, 2 to 3 mm thick, and 5 mm wide.

The samples of all four cartilage groups were incubated for 1 month. The samples were incubated in physiologic salt solution containing antibiotic-antimycotic agents. Each group included 10 cartilage preparations, and each group was incubated in 100 ml of the physiologic salt solution, separately. The physiologic salt solution was replaced with a fresh solution weekly. At the end of 4 weeks, cartilages were taken out and examined histopathologically to prove the vitality of the cartilages.[3]

Histopathologic examination was performed by an expert histologist, and no significant difference

Table 1. Mean Angles and p Values between Different Types of Cartilage Cuts

Angle	Compared with Angles	p
1 (1.344 ± 0.6146)	2	0.895
	3	0.026*
	4	0.355
2 (1.756 ± 0.7143)	1	0.895
	3	0.124
	4	0.768
3 (3.089 ± 1.6841)	1	0.026
	2	0.124
	4	0.563
4 (2.322 ± 1.5595)	1	0.355
	2	0.768
	3	0.563

*Statistically significant.