body image, audit processes and satisfaction with the results). The mean age was 23.8 years, most frequently females (69%). The most important maxillofacial diagnosis was maxillo-mandibular deformity (71%). Most of them had personal (60%) and aesthetic (86%) motivation for surgery. Personality traits have been considered as in the normal population. The body image (that was related with depression and neurotic personality), the self-concept and self-esteem after 1 year of the surgery were higher than before the surgical process (122 to 135, 102 to 120, 57 to 67). The satisfaction with the results was complete in 94%. So we think the orthognathic surgical patients are psychologically normal but they experience an important positive psychological changes because of the facial physical modifications that will, perhaps, be determinant for their lives.

Naso-Orbito-Ethmoid Fractures: A Review of our 20 Years' Experience

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The fronto-naso-orbito-ethmoidal region is traditionally described as one of the main susceptible areas exposed to craniofacial traumatology, not only for the risk to external damage but also especially for the multiple and complex anatomical structures that form it and its important aesthetic relevance. Our 20 years' experience is presented, emphasizing therapeutic procedures and complications and sequaellae of these traumatic injuries.

The Rank of Orbital Wall Reconstruction in Craniofacial Osteotomies

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There are two reasons for reconstruction of orbital walls. First, support of the mobilized fragments to hold them in the planned position. The second point is the prevention of dislocation of the orbital content out of the orbit. In order to prove this point we controlled a part of our patients with orbitotomies. In the sample were 91 orbitotomies in cases of late surgery and 45 orbitotomies in early surgery. We found no difference in cases of four wall, three wall, two wall and one wall orbitotomy. Our sample shows the necessity of orbital wall reconstruction in nearly all of the cases only to hold the mobilized fragment in the desired position. Very rarely we found the requirement of reconstruction to prevent the orbital content from dislocation, only in 3 cases did we see the necessity of grafting because of violation of the periorbit and, in possibly 1 case, because of a gap over 12 mm. That means, one can exclude the dislocation of the orbital content without bridging the walls if the periorbit is uninjured. Concerning the mobility of the globes, we found no change caused by gaps in the orbital walls. Disturbances are caused only by shifting the orbital axis.

Surgical Management of Accessory Parotid Gland Tumours

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Accessory parotid gland tumours are defined as masses within salivary gland tissue located adjacent to Stensen's duct, but separate from the main body of the parotid gland. We present our experience with 18 patients who had accessory parotid gland tumours. They comprised 1% of all primary tumours treated at our department during a 20 year period. There were 12 benign and 5 malignant tumours. Of the benign tumours, 10 were pleomorphic adenomas and 2 lymphoepithelial lesions. The histological classification of the 5 malignant tumours was: mucoepidermoid carcinoma in 3, acinic cell carcinoma in 1 and adenoid cystic carcinoma in 1. In our view, the best surgical approach to tumours of the accessory parotid gland is via the standard parotid incision. After raising a cervicofacial flap, one is permitted to fully visualize the superficial parts of the parotid gland, expose the main trunk of the facial nerve with careful tracing of all its branches (if necessary) and the accessory parotid gland along with Stensen's duct. Once the lesion was exposed, either local excision or resection in conjunction with subtotal parotidectomy was performed, depending on the clinical findings.

Epithetic Treatment Principles and the Use of Stereolithography

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In the age of stationary implanted epitheses, in addition to the patients with acquired facial deformations, patients with congenitally deformed or missing facial parts are moving to the foreground of epithetical treatment concepts. Where the use of adhesives or glass frames was required to mount epitheses, implant fixtures now make it possible to omit adhesives and glass frames and to mount the epithesis or hearing aid directly on the suprastructure. However, patients with dystoses in the cranial region manifest irregular bone structure, so that the planning and insertion of implants often deviates considerably from the rule. Stereolithography facilitates the computer-aided modelling of the bony portion of the splanchnocranium and the neurocranium in acrylate. This artificial cranium provides a clear basis for planning the placement of implants in accordance with epithetic and aesthetic goals. Together with traditional epithetic planning, stereolithography provides not only a new planning basis for epithetic implant care of dysostosis patients, but can also be used in the identification of changed bone structures after tumour removals.

How Does Secondary Trauma to the Optic Nerve Influence the Retinal Ganglion Cells?

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Afferent disorders are hardly predictable following head trauma; the head surgeon has to avoid additional harm to an injured visual system and not to exceed therapeutic time windows for repositioning and osteosynthesis of dislocated fractures. We created an animal model (Wistar rats), which