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Plastic Surgery:

Medical, Organizational & Polemical

Collected Works of Jacques W. Maliniac



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Plastic Surgery: Medical, Organizational & Polemical

COLLECTED WORKS OF JACQUES W. MALINIAC

Jacques W. Maliniac was born in Warsaw in 1889. He completed his medical education at the University of Paris in 1914. At that time, plastic surgery was a technique used especially for injuries from wars or accidents. While working in New York in 1925, Maliniac helped establish the plastic surgery department for the first time in a public hospital. Together with Gustave Aufricht, they argued that plastic surgery should also be used for aesthetic reasons. Both surgeons were Jewish and, noticing the rising antisemitism in Europe, they decided to stay in New York. They founded the American Society of Plastic and Reconstructive Surgeons with like-minded experts in plastic surgery. These efforts led to the transformation of plastic surgery into a commercial sector. During his career, he worked at Sydenham Hospital, Jewish Memorial Hospital, Beth Israel Hospital and St. Peter's Hospital.

Maliniac was a prolific surgeon. He not only wrote about his professional experiences, but also pioneered the conceptual construction of plastic surgery. At the same time, he made polemics with his colleagues about the direction of the communities they formed.

In his article, *Is the Surgical Restoration of the Aged Face Justified?* (1932), he mentioned that women in business lose their position as they age and that plastic surgery may be the solution. In *The War Organization of Plastic Surgery* he wrote in 1943, he said that hospitals should be prepared for plastic surgery immediately for wounded soldiers. In his article *The Plastic Surgeon and Crime* (1935), he emphasized that the records of people who performed plastic surgery should be kept by the police, giving the notorious criminal John Dillinger as an example.

This collection contains reprinted articles written by Maliniac in different periods. We understand from his introduction that he decided to compile this compilation in 1938. But even then, he didn't have all the articles he had written. And he added the articles he wrote after 1938 to this compilation. As a matter of fact, this collection was gifted to Turkish plastic surgeon Halit Ziya Konuralp in 1956.

Many of the articles in this collection, especially medical ones are available digitally, just a few available in print versions in libraries. Some are nowhere to be found. Also in this collection contains his book, *Breast Deformities and Their Repair*, published in 1950. Also, the collection itself, *Award to Dr. Maliniac* (1955), *A Challenge to Leadership in Organized Plastic Surgery* (1958) and his book *Breast Deformities and Their Repair* (1950) were autographed by Maliniac.

Reprint from THE LARYNGOLOGIST, St. Louis, October, 1931.

A SIMPLIFIED METHOD FOR CORRECTION OF DISHFACE

DR. JACQUES W. MALINIAK, New York.

The condition here described is characterized by the recession of the middle part of the face and lower part of the nose, with a prognathic chin.

Description: The most striking feature of a dishface is the disproportion between the prognathic chin and short upper jaw. The malformation of the jaws results in the malarrangement of the teeth. The deformity of the nose is characteristic; the lower part is held backwards, attached to the under-developed upper jaw, thus giving a lumped and flattened appearance; the alae are flattened and the nasal apertures narrowed. Preventive treatment is purely orthodontic and must be carried out in early childhood.

Repair of the Constituted Deformity: The depressed middle part of the face around the lower half of the nose must be raised by filling out the deficiency along the lower border of the aperture and the maxilla. A procedure which aims at the correction of this deformity consists in the affixation of a cartilaginous arch along the nasal aperture, thus advancing the depressed region. A cartilaginous transplant is introduced horizontally through an incision in the columella and properly affixed to the peristoma. In addition to this operative step, which aims to raise the depressed paranasal area, a proper reconstruction of the nose is required. The method which we find most suitable for the repair of this deformity follows:

An incision is made on the middle part of the philtrum and slightly continued on the upper lip, through which an undermining of the lip and alae is done. The horizontal tunnelling should not exceed one-half-inch in diameter and extend to the insertion of the alae on each side.

A free rib cartilage graft, about one-third of an inch wide and about three inches long, is removed from the seventh or eighth rib cartilage, leaving the perichondrium attached to the inner surface. The graft is prepared so as to thoroughly preserve the best appearance approaching the semicircle (Fig. 1-A). In the middle of the arched graft a small opening is made for the insertion of a short cartilaginous graft extending from the anterior nasal spine towards

A Simplified Method for Correction of Dishface (1931)

Reprinted from the Medical Journal and Record for January 21, 1931.

COMPARATIVE VALUE OF SURGICAL PROCEDURES IN REPAIR OF SKIN DEFECTS*

JACQUES W. MALINIAK, M.D.

Plastic Surg., Sydenham and Beth Israel Hosp., New York; Consulting Plastic Surg., St. Peter's Hosp., New Jersey, N. J.; Plastic Surg., Beth'g. Hosp., Newark, N. J.

New York

Skin grafting, in its many forms, has for centuries been the keynote in reconstructive surgery, as difficulties have been encountered, not only in the past, but also in recent years in dealing with this problem. The replacement of wide skin disfigurements and scars by a skin of normal color and texture was for a long time the goal of the surgeon, especially when these disfigurements were on exposed parts of the body, as the face and neck. Only a limited amount of skin area can be excised at one time without interfering with the immediate closure of the defect. The complete repair of a wide skin area in one stage would require one of the usual methods of skin grafting, such as the use of a free or pedicled graft. It goes without saying that even the most successful free skin grafting leaves a distinct mark, as the transplanted skin rarely matches the color and texture of the adjacent area, not to mention the unavoidable scars surrounding the grafted region. A facial pedicle flap for the repair of defects of the face is the only one which would match this region but it may not always be available, and aside from this, in preparing this flap, we cause further mutilation.

METHOD OF REPEATED PARTIAL EXCISIONS

The ideal result can be approached only by cov-

*Read before the Surgical Section of the Academy of Medicine of Northern New Jersey, April 10, 1930.

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Comparative Value of Surgical Procedures in Repair of Skin Defects (1931)

Reprinted from the Medical Journal and Record for April 6, 1932

IS THE SURGICAL RESTORATION OF THE AGED FACE JUSTIFIED?

Indications—Method of Repair—End Results

JACQUES W. MALINIAK, M.D.

New York

The aged face is a physiological fatality often appearing in relatively young people. The strain of present day life, the abusive use of cosmetics and hereditary predisposition are important contributing factors.

Hitherto, this subject has received little attention in medical literature in spite of the ever increasing demand for this type of surgery. The following points are of interest if the surgical repair of the aging skin is to be properly estimated: Should a woman with a prematurely aged face resort to surgical measures if a noticeable improvement can be obtained without undue risk? What types of deformities warrant surgical repair? What are the contraindications, methods of repair and end results?

SOCIAL AND PSYCHOLOGICAL FACTORS

Conspicuous folds and bags around the eyes and mouth with flabbiness of the cheeks and neck can be successfully eradicated by means of surgery, provided the cases are properly selected and the surgical method of choice used.

There are women in the late thirties who often lose their positions in business because they "look too old." This also applies to those who follow the stage and screen, where a youthful appearance is one of the main requisites. In addition to this, there are many intimate requirements which make it necessary

*Abstract of a paper presented before the French Society of Plastic and Reconstructive Surgery, Paris, February, 1932.

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Is the Surgical Restoration of the Aged Face Justified? (1932)

Reprinted from the Medical Record for June 29, 1934

ASPECTS OF PLASTIC SURGERY SELDOM CONSIDERED*

JACQUES W. MALINIAK, M.D.

New York

To those of us who have been struggling to establish plastic and reconstructive surgery on an equal basis with other medical specialties, it is profoundly gratifying to see an audience of this caliber assembled at the second annual meeting of our society. Your presence here is indicative of the growing interest in the technical procedures employed in the repair of deformity, and I will not permit my desire to welcome you to delay the presentation of the excellent papers that have been prepared.

I cannot, however, let this occasion go by without reminding you of the numerous paramedical problems that stand in the way of realizing the full benefits of reparative surgery for our profession and for the community we serve. It is our belief that a better understanding of these problems by physicians at large would materially hasten their solution and secure distinct and measurable advantages for all concerned.

Neglect of Organization

Many elements enter into the failure of the profession to further the establishment of plastic and reconstructive surgery as an organized specialty. Certain of these obstructive factors are controlled by the individual practitioner. Organized medicine and those in charge of medical education must assume responsibility for others.

*Chairman's address delivered at the second annual meeting of the Society of Plastic and Reconstructive Surgery, October 15, 1933.

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Aspects of Plastic Surgery Seldom Considered (1934)

Reprinted from the January, 1934, issue of MEDICAL ECONOMICS The Business Magazine of the Medical Profession RUTHERFORD • NEW JERSEY

MEDICINE'S STEPCILD

By Jacques W. Maliniak, M.D.

Medicine's Stepchild (1934)

SOME LEGAL AND ILLEGAL ASPECTS OF PLASTIC SURGERY

JACQUES W. MALINIAK, M.D.

New York, N. Y.

Reprinted from the Medical Times and Law Review Medical Journal, New York, June, 1934

Some Legal and Illegal Aspects of Plastic Surgery (1934)

PREVENTION OF NECROSIS IN PLASTIC REPAIR OF THE BREAST

JACQUES W. MALINIAK, M.D.

NEW YORK CITY

REPRINTED FROM NEW SERIES VOL. XXVI, NO. 2, NOVEMBER, 1934, PAGES 392-397

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Prevention of Necrosis in Plastic Repair of the Breast (1934)

Reprinted from the Archives of Surgery May 1937, Vol. 34, pp. 89-93

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REPAIR OF FACIAL DEFECTS WITH SPECIAL REFERENCE TO THE SOURCE OF SKIN GRAFTS

JACQUES W. MALINIAK, M.D.

NEW YORK

The repair of a defect on an exposed part of the body, such as the face or neck, presents certain special problems. No matter where a raw surface occurs, it should be covered promptly in order to expedite healing, restore comfort and reestablish proper function. If it is on an exposed area, the added factor of appearance must be considered.

It is not the purpose of this communication to describe the technic involved in obtaining and applying different types of grafts and flaps but to consider their respective suitability for the repair of various defects of the face and neck. The possibilities of deformity in these regions are so vast and varied, owing to a wide range of congenital, traumatic and surgical causes, that to a certain extent each case must be considered an individual problem. Several accepted procedures may suggest themselves for the repair of a given defect, and it is not always easy to decide on the method which best suits the requirements of the particular case.

GENERAL CONSIDERATIONS

So far as it is possible to generalize, the attainable cosmetic result is a decisive factor in the selection of a procedure—subject, of course, to the size, location and etiology of the deformity, the vitality of the surrounding structures, the age and sex of the patient and the simplicity of the method under consideration. In an old man the cosmetic element would not loom as large as in a young woman, while in the latter appearance is so important as to outweigh even simplicity of technic. The tissues employed in the repair must resemble the surrounding structures as nearly as possible, even if slight additional scarring is entailed, and they must be such as to retain their characteristics in the distant future. The sliding or rotating flap is the ideal procedure in every case, but skin may not be available for this because of the size or location of the defect (figs. 1 to 6).

When a defect cannot be eradicated by approximating the surrounding edges of the skin, the choice lies among various types of free grafts

*Presented before the First European Congress of Reconstructive Surgery, Brussels, Belgium, Oct. 4, 1936.

Repair of Facial Defects with Special Reference to the Source of Skin Grafts (1937)

BREAST DEFORMITIES ANATOMICAL AND PHYSIOLOGICAL CONSIDERATIONS IN PLASTIC REPAIR*

JACQUES W. MALINIAK, M.D.

NEW YORK CITY

INTRODUCTION

SUCCESSFUL plastic repair of the female breast demands complete familiarity with the anatomy and physiology of the structures involved. The interstitial or epithelial hyperplasia of a hypertrophic breast may signify a precancerous condition or early malignancy whose surgical treatment is entirely different from the correction of a benign hypertrophy. An accurate differential diagnosis whose surgical treatment is entirely different from plastic reconstruction. This is impossible without full knowledge of the evolutionary and functional changes the mammary structures undergo. In this paper a few anatomical and physiological points are considered with respect to the etiologic factors in mammary deformities and the choice of surgical procedures for their repair.

PHYSIOLOGY

Embryonic Development. Traced from its embryonal origins, the breast first appears as an epidermal ridge extending from the axilla to the groin. Certain points of this ridge are thickened, forming the mammary glands. When the so-called "milk spots" (which are believed to derive from the sweat glands) develop unduly, accessory breasts appear at different points on the site of the epidermal ridge (Figs. 1 and 2).

Infancy. At birth the breasts consist of epithelial columns without lumens, but they soon undergo change. The ducts assume definite cylindrical form and a milky fluid may be produced. These characteristic alterations occur in boys as well as girls. The process is completed shortly after the first year of life.

Adulthood. At the onset of life and the epithelium returns to a quiescent state. Until puberty there is no further change. The gland measures about 2 cm. in diameter and 1 cm. in thickness.

Puberty. At puberty the female breast begins to develop, reaching adult form and proportions within a varying period of time. The normal breast is made up principally of connective tissue, with comparatively little fat and glandular structure. This gives it a characteristic resilience. At this period of life, the breast is usually a firm hemisphere which varies little with change of position; for the connective tissue bands which control its form have not yet sustained the repeated congestions produced by mammary function (Fig. 3).

In addition to function and age, individual, hereditary and racial characteristics—manifested in the proportion of fat, fibrous, epithelial and glandular elements—play an important role in determining the form of the breast. When fibrous tissue predominates, the organ is firm. It is soft and pendulous in the presence of excessive fatty tissue.

Pregnancy and Lactation. Omitting the periodic changes of menstruation (when the tissue is oedematous), the fiber thicker and the epithelium becomes taller and stains more deeply the next great alteration in the breast occurs during pregnancy. Its volume increases, especially after the third month, and the functional growth of the gland causes a distention of almost all its elements. The ducts are stretched and the tissue loses its hemispherical form. The skin covers it stretched and may show distention scars (striæ) similar to those which appear on the abdominal wall.

*From the Department of Plastic Surgery, Sydenham Hospital, New York, N. Y.

Breast Deformities Anatomical and Physiological Considerations in Plastic Repair (1938)

A CHALLENGE TO LEADERSHIP IN ORGANIZED PLASTIC SURGERY

JACQUES W. MALINIAC, New York, N.Y.

Since this paper was considered by the Journal of Plastic and Reconstructive Surgery as a controversial subject for publication, it is made available to the profession in the present form.

It is fully realized that this message may appear to be too spoken to some of my friends. It is not intended, however, to reflect on anyone in particular. Its sole objective is to contribute some enlightenment to the many problems which confront us.

Constructive suggestions on the matters discussed in this paper are invited from the members of the American Society of Plastic and Reconstructive Surgery. These should contribute to the preparation of a report by a special committee.

These lines are submitted to clarify statements made in a paper published in the Journal of Plastic and Reconstructive Surgery, especially in order to bring to the attention of American surgeons the education and because of the position of the Journal and the effect which it may have upon action in foreign lands. Confusion may arise in a number of cases if its contents as it contradicts the factual data on the subject.

Am referring to the following excerpts which express the position of the Association:

At our last meeting we filled our quota of membership (of 300) and, for the first time in its history, increased the number of members. This increase was not intended simply to add more members but to add to our organization outstanding ability, integrity and ethical standards who will be leaders. Membership in the American Society of Plastic and Reconstructive Surgery should be held by those who are not only men of great education and ability, but also those who are qualified to assume the responsibilities of leadership. Those who are not qualified to assume these responsibilities should not be admitted. Our objectives . . . should include the stimulation and improvement of public understanding of our services.

The Journal of Plastic and Reconstructive Surgery, Vol. 20, No. 2, 1957, p. 197.

A Challenge to Leadership in Organized Plastic Surgery (1957-58)

RECONSTRUCTION OF DEFORMED CHIN IN ITS RELATIONSHIP TO RHINOPLASTY

DERMAL GRAFT—PROCEDURE OF CHOICE

JACQUES W. MALINIAC, M.D.
Attending Plastic Surgeon, Strohman and Jewish Memorial Hospitals
NEW YORK CITY

CORRECTIVE rhinoplasty has come to be one of the most common procedures in reparative surgery. In principle frequently results in a favorable post-operative profile which is a source of much dissatisfaction to the patient.



As a rule, once established they remain permanent, with no tendency to reduction in size. There is often a disposition to an increased growth of hair. The bleb is benign unless constantly irritated, when degenerative changes may set in.

Treatment. When small, the benign growth is easily destroyed by desiccation or by means of a keratolytic substance (trichloroacetic acid, etc.). This procedure is inadvisable for flat nevi, even of small size, as it normally produces a depressed scar. Excision with fine approximation results in a linear scar which is generally less conspicuous than a round depressed one.

In large nevi, use of the electric needle or a keratolytic substance is contraindicated because of the long time such treatment requires and the conspicuous scarring which is inevitably produced. The disfigurement usually requires reparative surgery at a late date. Besides, repeated prolonged treatment is extremely difficult, if not impossible, in small children, who represent the majority of cases.

Radiation therapy has been advocated in the treatment of pigmented nevi. The use with which it can be applied is responsible for abuses in its use. Authorities are of opinion on this matter is clearly expressed by McKee,¹ who states that "X-rays and radium are not indicated in . . .

In outlining the correction, a sketch tent is being focused on concomitant abnormalities of other components of the face and their relationship to the nose. A reconstructed nose should not merely be inconspicuous; it should harmonize with the rest of the profile, particularly the forehead and chin. Failure to observe this principle frequently results in a favorable post-operative profile which is a source of much dissatisfaction to the patient.

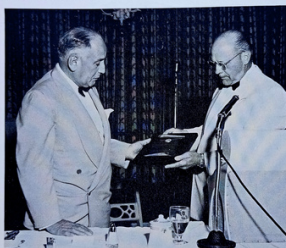
Reprinted from the June, 1938 issue of *The American Journal of Surgery*, Vol. 52, Pt. 2, p. 67.

Reconstruction of Deformed Chin in its Relationship to Rhinoplasty (1938)

AWARD TO DR. MALINIAC

The 1934 Special Honorary Citation Award of the American Society of Plastic and Reconstructive Surgery was presented to Jacques W. Maliniac, M.D., by Dr. Clarence R. Strassman, at the Twenty-Third Annual Meeting of the Society at Hollywood Beach, Florida, October 26, 1934. (See accompanying photograph). In making the presentation Dr. Strassman said:

Tonight I have been given the privilege of awarding this Society's annual citation to the man who founded our organization.



It began in the fall of 1930 when Dr. Maliniac invited about a dozen men interested in various phases of plastic surgery to a dinner at the Physicians' Club in New York for the purpose of discussing a society of plastic surgery. From this small group an organization was founded in 1931 with ten founder members. The man who was elected president of this society was Dr. Maliniac, serving for the years 1932 to 1933. I can well remember when after much discussion the membership was raised from 25 to 50. At this meeting an amended constitution was adopted increasing our membership from 200 to 400 to be voted upon.

Jacques Maliniac received most of his education in France—his college and pre-medical training from the University of Nancy, (France) and his medical . . .

Reprinted from *Plastic and Reconstructive Surgery*, Vol. 18, No. 2, February, 1953, p. 197.

Award to Dr. Maliniac (1955)

PREVENTION AND TREATMENT OF LATE SEQUELAE IN CORRECTIVE RHINOPLASTY*

JACQUES W. MALINIAC, M.D.
NEW YORK, NEW YORK

PHYSICIANS in all branches of medicine are consulted with increasing frequency about late sequelae of corrective rhinoplasty. To answer such inquiries authoritatively, they must be familiar with the sequelae which may follow a successful repair and understand the factors which enter into their prevention and treatment. This paper will discuss late sequelae and their treatment. It will not include repair of partial or total loss of nose, except for post-traumatic complications.

GENERAL CONSIDERATIONS

It is logical to start with the qualifications of the rhinoplasty surgeon. He must have a thorough knowledge of the anatomy, recognize local pathology and to ensure adequate endonasal and proper handling of tissues in the nasal cavity. He must also have an understanding of the purely plastic factors involved in reconstruction of the nose.

There is also a definite art to rhinoplasty. The degree of elevation above the ideal profile line indicates the amount of tissue and cartilage to be removed from the dorsum. Preoperative study of the patient with a photometer or protractor helps to plan the proper facial angle and determine how much of the osteocartilaginous frame to remove or add.

According to the normal ethnic canon, the lower level of the cutaneous septum should be decidedly below the level of the nostrils. Another important point is the length of the nose from tip to tip. This . . .

Reprinted from the September, 1939 issue of *The American Journal of Surgery*, Vol. 58, Pt. 2, p. 67.

Prevention and Treatment of Late Sequelae in Corrective Rhinoplasty (1940)

PIGMENTED NEVI WITH SPECIAL REFERENCE TO THEIR SURGICAL TREATMENT

JACQUES W. MALINIAC, M.D.
NEW YORK CITY

LARGE nevi and hairy moles are skin lesions which are particularly conspicuous when located on the face. They then present a difficult dermatologic problem.

Pathologically they represent a circumscribed increase of skin pigment, often associated with hypertrophy of one or all the cutaneous structures, especially connective tissue and hair.

As a rule, once established they remain permanent, with no tendency to reduction in size. There is often a disposition to an increased growth of hair. The bleb is benign unless constantly irritated, when degenerative changes may set in.

Treatment. When small, the benign growth is easily destroyed by desiccation or by means of a keratolytic substance (trichloroacetic acid, etc.). This procedure is inadvisable for flat nevi, even of small size, as it normally produces a depressed scar. Excision with fine approximation results in a linear scar which is generally less conspicuous than a round depressed one.

In large nevi, use of the electric needle or a keratolytic substance is contraindicated because of the long time such treatment requires and the conspicuous scarring which is inevitably produced. The disfigurement usually requires reparative surgery at a late date. Besides, repeated prolonged treatment is extremely difficult, if not impossible, in small children, who represent the majority of cases.

Radiation therapy has been advocated in the treatment of pigmented nevi. The use with which it can be applied is responsible for abuses in its use. Authorities are of opinion on this matter is clearly expressed by McKee,¹ who states that "X-rays and radium are not indicated in . . .

Reprinted from the September, 1939 issue of *The American Journal of Surgery*, Vol. 58, Pt. 2, p. 67.

Pigmented Nevi with Special Reference to their Surgical Treatment (1939)

A MAMMAPLASTIC SUBSTITUTE FOR AMPUTATION IN HYPERTROPHIES

JACQUES W. MALINIAC, M.D., NEW YORK, N. Y.

GENERAL CONSIDERATIONS

The following modification of the classical submammary procedure has proved a satisfactory substitute for amputation with free grafting of the nipple in several types of massive hypertrophy. It is particularly indicated when reduction of the posterior aspect of the breast is the chief objective and retention of areolarity in the nipple is an important consideration. It cannot be employed when the areola is greatly enlarged.

The preliminary approach was first described by Thomas¹ and Warren² for the removal of benign tumors. Subsequently Gannari³ and Moseley⁴ followed this route for plastic excision in breast hypertrophies. Apparently none of these authors recognized the necessity for plastic reconstruction of the skin covering to impart proper form, and adequate maturation to ensure permanence of results.

The great advantage of the submammary route lies in its safety. It permits wide exposure of the posterior aspect of the breast and extensive glandular resection without jeopardy to the main mammary blood supply and its peripheral ramifications⁵ (Fig. 1). It also facilitates aeration of the breast to the postoperative stage.

Because of its safety factors, this procedure can often be carried out in one stage. However, two stages are preferable, allowing greater attention to detail in the pursuit of an optimum end result.

PROCEDURE

Glandular Resection.—An incision is made in the submammary fold, through which the posterior surface of the breast is bluntly separated along the retroaxillary aponeurosis as far as the second intercostal space. The breast is then turned over on the chest and its posterior aspect exposed for glandular resection. The type of excision varies with the nature and degree of the hypertrophy (Fig. 2).

Reduction of the gland is effected in such manner as to preserve the bulk of its central portion. Excisions are made in the external and lower quadrants, where enlargement is usually greatest. As a rule bleeding is minimal because of the disposition of the blood supply; the surgical area can be shaped without danger of interference with the main vascularization of the nipple.

In enlargements associated with isolated benign tumors (cysts, fibroadenomas, etc.), a number of V-shaped segments can be taken from the entire thickness of the gland, each including one or more growths. No attempt is made to desiccate cysts as they are usually adherent to the surrounding tissue and may open during the process of separation. If it is absent appears . . .

Reprinted from *Plastic and Reconstructive Surgery*, Vol. 18, No. 4, April, 1953, p. 197.

A Mammoplasty Substitute for Amputation in Hypertrophies (1949)

EVALUATION OF PRINCIPAL MAMMAPLASTIC PROCEDURES

JACQUES W. MALINIAC, M.D.

Although reparative surgery on the deformed breast has been extensively discussed in the medical literature in the past quarter of a century, there is little to guide the surgeon in his choice of methods. Many procedures are described without a supporting report of the number of cases in which they have been used and the results obtained. There is no basis for critical appraisal. As a result, safe and effective techniques are sometimes ignored in favor of methods which disregard fundamental anatomical and physiological requirements.

To some extent this lack of determination stems from the absence of precise objectives. Too often the surgeon sets reduction in size as his sole aim without regard for good contour, aesthetic details and preservation of function. Acceptable mammoplasty must produce the best possible functional and cosmetic result. It must take into consideration the possibility of metaplastic changes in the breast tissue, of scars or of any other pathological elements creating special problems.

STANDARDS OF CRITERIA

Every mammoplasty procedure embraces three main steps: (1) the shaping of skin flaps; (2) the formation of glandular pedicles; and (3) mastopexy. Equally important, it must include planning for symmetry and sculptural appreciation of normal form.

Safety

In shaping the skin flaps and creating the glandular pedicles, success depends in large measure on preservation of the blood supply. Without the necessary safeguard necrosis of skin and gland is an ever-present hazard.

I have previously pointed out the macrorrhysis which have crept into so-called classical descriptions of the blood supply of the breast. Without enlarging on the subject here, suffice it to summarize those elements which are essential to the evaluation of mammoplasty techniques.

1. A balance is usually maintained between the two main internal and external vascular pedicles. In approximately 55 percent of cases the thoracic lateral artery plays an equal part with the internal mammary in the vascularization of gland and nipple; in 13 percent it has a predominant role. This counterbalances excision of the external or internal half of the breast.
2. The disposition of the two main internal and external vascular pedicles precludes excision of upper internal and lower glandular vessels.
3. To an even greater extent it allows resection of the upper half of the gland (Table I).

To facilitate total removal of the epithelium, it is advisable to cover same with a covering flaps such as brilliant goss.

Reprinted from *Plastic and Reconstructive Surgery*, Vol. 4, No. 4, July, 1949.

Evaluation of Principal Mammoplasty Procedures (1949)

COMPRESSIVE SUSPENSION SPLINT FOR POSTOPERATIVE AND ACCIDENTAL COMMUNED NASAL FRACTURES

J. W. MALINIAC, M.D.
NEW YORK, N. Y.

Reprinted from the September, 1939 issue of *The American Journal of Surgery*, Vol. 58, Pt. 2, p. 67.

Compressive Suspension Splint for Postoperative and Accidental Comminuted Nasal Fractures (1948)

REPORT OF THE FOUNDATION FOR 1952-1953

COMMENTS AND SUGGESTIONS FOR THE FUTURE

JACQUES W. MALINIAC, M.D.
New York, New York

We are now entering the sixth year since the establishment of the Foundation of this Society. This, the Fourth Annual Report, which I have presented, seeks to acquaint the membership with our activities and progress during 1952-53, and to comment on the experiences gained.

It must be borne in mind that we had no precedent to guide us; our work was the first attempt to arrange scholarships in the medical field, on a quarter-basis. We were therefore, constrained to proceed cautiously and learn from our own experience. In the international sphere, current psychological and financial stress complicated our task. We sailed an uncharted sea and had to find our way by trial and error.

1952 ESSAY CONTEST

In 1952, no full scholarships were awarded. Instead, five certificates of Honorable Mention were given in the Junior and Senior classifications.

To evaluate available arrangements with Plastic Centers, and to test the workability of the proposed exchange, partial scholarships of two months each were given to the holders of certificates. They were assumed full maintenance in the services listed, and were given \$100.00 each for local traveling expenses.

American in need of further financial aid could obtain a loan, to be repaid without interest within a reasonable length of time. This arrangement was made possible by individual gifts established by a number of members of the Society.

Misses John F. North and C. M. McLaughlin of Great Britain arrived in the United States early this year for a two-month stay.

Dr. Sten Stenstrom of Sweden, was unable to avail himself of his two months' scholarship at that time and we extended his time limit to the end of this year. He is expected in this country in November.

Dr. Raymond Brunst elected to go abroad and is scheduled to report on his experiences at this meeting. Publication of such reports by all award winners will be made obligatory in the future.

We wish to acknowledge our appreciation to the following chiefs of service for the hospitality extended during the year to our foreign visitors: Dr. James Burnett Brown, Herbert Conway, Berthold Frederik Figli, Paul Greiner, Lyndon Perry, and Ferris Smith.

From comments received, we are satisfied that the scholarship winners and the staff of the host-servicing hospitals monthly. The visitors were to . . .

Received for Publication December 12, 1953.
Presented at the Meeting of the American Society of Plastic and Reconstructive Surgery, Coronado, California, November 4, 1953.

Report of the Foundation for 1952-1953 (1954)

USE OF PEDICLE DERMO-FAT FLAP IN MAMMAPLASTY
JACQUES W. MALINIAC, M.D.

ONE of the chief potential dangers in mammoplasty is interference with the blood supply. The breast is a highly vascular organ and its surgical reconstruction usually demands the formation of skin flaps and glandular pedicles, during which process some vessels are likely to be severed. Unless adequate vascularization is preserved, necrosis of the skin and glandular structures will be inevitable. A clear understanding of the vascular distribution is essential to prevent this. Unfortunately many inaccuracies have crept into the literature on this subject. The classical description of the old anatomists rests on many points and most of the modern authors until a few years ago, including the writer, accepted these faulty data. Since the use of roentgenographic studies of injected vessels, however, a more complete and accurate picture is available. The chief difference lies in the upper pole attributed to the thoracic lateral artery in mammary vascularization. The writer has elsewhere described fully the arterial blood supply of the breast as revealed by recent investigations. This paper will discuss the author's two-stage procedure in relation to some of the salient features of mammary vascularization.

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(1953)

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Two-Stage Mammoplasty in Relation to Blood Supply
(1945)

THE scope and practical application of plastic surgery hold particular interest for New York physicians because of the important organizational developments which had their origin here. In 1910 a regular plastic division was established in the New York City Department of Hospitals—the first in the country to afford specialized service to the indigent in this field. In 1931 the American Society of Plastic and Reconstructive Surgery, now the leading association in this sphere, was organized here. Moreover, because of its size and complexity, New York has an unparalleled concentration of clinical material demanding recourse to plastic surgery. Traffic and industrial accidents, an enormous population with its congenital and acquired deformities, all contribute to the vast number of individuals who require plastic reconstruction in some form. All too often they are diverted from their proper attention by their own ignorance, sometimes by a misapprehension in the profession itself, the role and potentialities of plastic repair.

Practical Scope of Plastic Surgery
(1949)

THE POOL OF PLASTIC SURGERY CENTERS AND THE ANNUAL SCHOLARSHIP CONTEST OF THE FOUNDATION OF THE AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

JACQUES W. MALINIAC, M.D.
New York, N. Y.

Detailed information pertaining to the development of the Foundation of the American Society of Plastic and Reconstructive Surgery, Inc. is available in the annual reports published in "Plastic and Reconstructive Surgery" since 1931 (1-8). Some additional data pertaining to the inclusion of the plastic centers in the F's project are to be considered here. A complete up-to-date list of the services is attached.

Our method of procedure was based on the widely accepted assumption that an exchange of scholars in various fields of endeavor greatly contributes to a better mutual understanding as well as broadening of intellectual horizons. Such an exchange of men, selected on a basis of annual Scholarship Contests, should be of particular value in providing leaders with mature wisdom and broad interests in various fields of medicine, including ours.

With this in view, a project of a Foundation was started in 1948 under the auspices of The American Society of Plastic and Reconstructive Surgery, Inc. The support given to the F's program by the Society, made possible within a few years, the establishment of a Scholarship exchange based on reciprocal agreements. This required six years (1950-56) of personal contacts and correspondence with leading plastic surgeons on the American continent and abroad.

In December, 1954, a detailed final Questionnaire was forwarded to the entire membership of the Society, for the purpose of obtaining accurate data with regard to listing of the plastic centers in the Foundation's pool. Leading foreign plastic centers abroad have been surveyed for this purpose, since 1951.

The survey of 102 aperiodic Questionnaires returned from the plastic surgery centers in the United States and Canada revealed that 43 pledged themselves to accept the award holders in their services for periods of time varying from 4 days to 4 months.

The great majority of these services also pledged to receive *external guests*, and *award holders*, for brief visits.

Twenty-seven of these in foreign countries subscribed to *full or limited reciprocal arrangements* for award holders. They are located in the following countries: Argentina—2; Brazil—1; British Isles—13; France—5; Germany—1; Mexico—1; and Sweden—3.

The following Nationals were recipients in the F's Scholarships since 1951: 12 Americans, 4 Britishers, 2 Argentines, 2 Swedes, and 1 Chinese.

* Free full maintenance in the services is extended to award holders and endorsed guests.

The Pool of Plastic Surgery Centers and the Annual Scholarship Contest of the Foundation
(1956)

RACTURE-DISLOCATIONS OF THE CARTILAGINOUS NOSE
ANATOMICAL AND CLINICAL CONSIDERATIONS AND TREATMENT
JACQUES W. MALINIAC, M.D.
NEW YORK

While the pathology and treatment of bony nasal fractures are well established, the results of injury to the cartilaginous components of the nose, being less definite, are often misinterpreted. In this paper I shall discuss dislocations of the cartilaginous nasal structures and their relationship to external deformities and outline a method of reconstruction based on the anatomic changes resulting from trauma.

ANATOMICAL CONSIDERATIONS

The chondrocartilaginous structure of the nose is based on the position and interrelationship of the septum and the lateral cartilages on the one hand, and the bony framework, on the other.

The septal cartilage is solidly fixed in a bony angle formed by the perpendicular plate and the vomer (Fig. 1A). The topography of its anterior border is of great surgical importance. The upper border of the vomer projects into the varying depth in which the septum is affixed and widens a cartilaginous prolongation often extends toward the sphenoid bone. The maxillary bone and the nasal spine in front of the vomer, being flat and slightly oblique, offer a sliding surface for the quadrangular cartilage. The perichondrium, together with the periosseum, forms a strong capsule resembling the mobility of the septum in this area. Thus the lower border of the septal cartilage, well affixed posteriorly in the groove of the vomer, becomes looser over the maxillary bone and the sphenoid nasal spine. This also represents its zone of active growth; it is at this level that new folds of the septum which extend along the vomerocartilaginous articulation.

R. articulation of the septum on the vomer (F. 2). In infants and young children the septum is nearly always straight. Only at the age of 10 years does the depression of the vomer become more pronounced.

2. Joseph's procedure for the correction of a cartilaginous deformity is illustrated in the lateral view of the nose. The arrow before C indicates the lateral border of the septum.

3. Joseph's procedure for the correction of a cartilaginous deformity is illustrated in the lateral view of the nose. The arrow before C indicates the lateral border of the septum. A shaded area representing a bony bridge is shown in the view of the nose. A shaded area representing a bony bridge is shown in the view of the nose. A shaded area representing a bony bridge is shown in the view of the nose.

Fracture-Dislocations of the Cartilaginous Nose
(1945)

THE war has brought to the attention of the American people the importance of plastic surgery. It has shown that plastic surgery is not only a branch of medicine, but a science that can save lives and restore the appearance of those who have been injured in battle. The war has also shown that plastic surgery is a team effort, requiring the cooperation of many different branches of medicine. The war has also shown that plastic surgery is a profession that is constantly growing and changing. The war has also shown that plastic surgery is a profession that is constantly growing and changing.

War Organization of Plastic Surgery
(1943)

RECONSTRUCTION FOR PARTIAL LOSS OF EAR

Case Reports.
JACQUES W. MALINIAC, M.D.

It is generally admitted that it is difficult to attain perfection in plastic repair of total or partial loss of ear. The main reasons for this are the intricate form of the auricle and the thinness of the skin and cartilage frame. Another problem is to set the reconstructed auricle at a proper distance from the head. Moreover, an apparently suitable cartilaginous graft and skin covering made available at the time of surgery may subsequently undergo changes due to scar formation and partial absorption of the graft; this eventually compromises the contour and position of the reconstructed ear.

The cases presented here are shown not for the purpose of demonstrating any particular procedure, but rather to bring out the difficulties encountered and the necessity for improvising individualized methods of repair. In both instances, the intracartilaginous skin directly adjacent to the defects and usually utilized in the repair was not available because of scarring. The location of the loss in the upper part of the auricle (case 1) rendered adequate skin grafting of the retroauricular area inadvisable for fear of producing a secondary deformity by replacing hair-bearing skin with a skin graft.

In one of the cases (case 2) a firm retroauricular tube was used instead of the supraorbital tube flap long considered a good reproduction of the helix. This narrow tube could have been considered risky in a small child. However, when properly delayed with an intermediary bridge to assure adequate blood supply, it served well and results in a fair skin with a less conspicuous scar. The supraorbital skin tube should include a limited amount of subcutaneous fat in order to simulate the fairly shaped helix.

Case 1. Adult male, showing loss of upper auricle following road injury, during which partial and supra-auricular laceration (Fig. 1). The patient was first seen by me in 1941, nine years after the injury. An attempt had been made elsewhere to repair the loss by means of a flap had been returned to the donor site having additional scarring.

The necessity for a normal foundation for repair of the loss required shifting of the skin temple nearer the ear. In view of the scarring on the temple and the loss of the helix, it would have required the sacrifice of the hair-bearing surface on the temple and thus have amounted to available skin and an additional secondary skin graft. In the usual location used to replace the skin loss on the auricle. A supraorbital tube flap was used to reconstruct the helix (Fig. 10).

* Presented at the Annual Meeting of the American Society of Plastic and Reconstructive Surgery, New York City, October 18, 1948.

Reconstruction for Partial Loss of Ear
(1946)

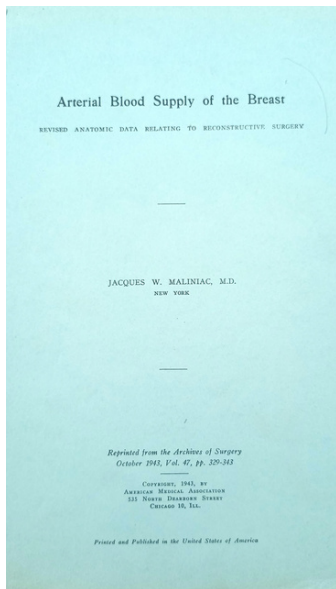
JACQUES W. MALINIAC, M.D.
NEW YORK, NEW YORK

THE use of free skin grafts versus flaps in the treatment of surface defects of the face and neck is a subject of great importance. The choice between the two methods depends on many factors, including the location and extent of the defect, the patient's age and general health, and the surgeon's preference. Free skin grafts are often used for large defects, while flaps are preferred for smaller defects and for areas where a better contour and color match are desired.

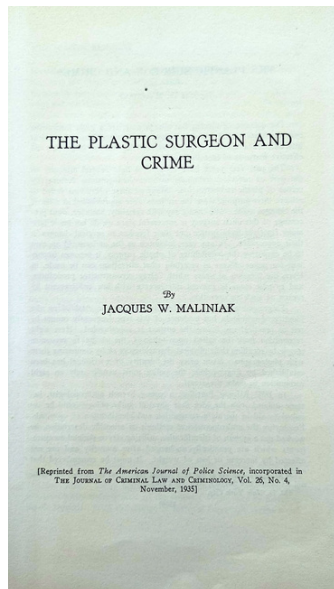
Free Skin Grafts Versus Flaps
(1942)

*Based on author's publications in Plastic and Reconstructive Surgery: 1. "Amputation Versus Transposition Of Glands And Nipple In Mammoplasty", Vol. 3, No. 1, January, 1948. 2. "Reduction Of Primary Mammoplasty Procedure", Vol. 4, No. 4, July, 1949. 3. "Use Of Pedicle Dermo-Fat Flap In Mammoplasty", Vol. 12, No. 2, August, 1953. Also, "Mammoplasty Procedures In Distinct And Underdeveloped Glands", Presented at the Meeting of the American Society of Plastic and Reconstructive Surgery, San Francisco, 16 Publication.

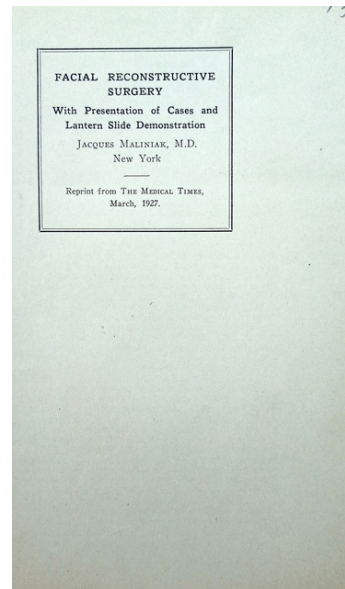
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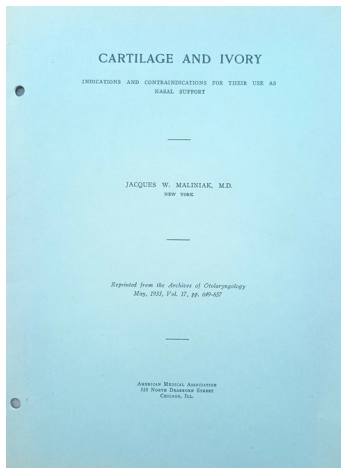
Arterial Blood Supply of the Breast (1943)



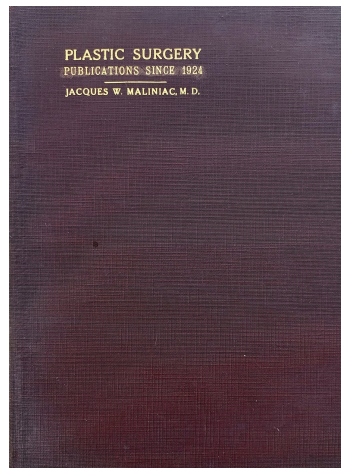
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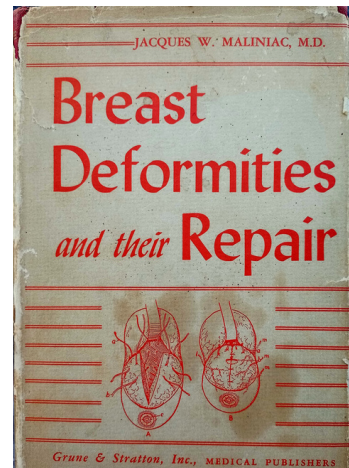
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