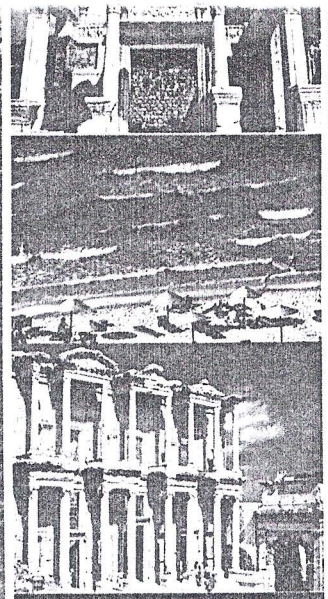

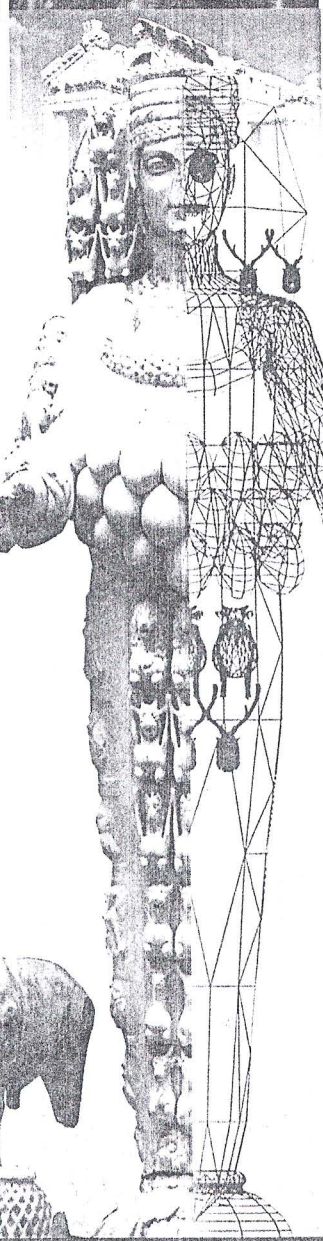

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Abstract Book

frequently used as a donor site, due to the easy access and the nerve is relatively large. But, when parotidectomy, rhytidectomy and platysma flap operation are performed, the GAN is often sacrificed. The purpose of this research provides basic data of the GAN as donor nerve and clears the topography of the GAN. We used 23 embalmed, hemifacial Korean cadavers. The all specimens was stained as Luxol fast blue and calibrated on the image analysis system.

The GAN was divided into anterior branch and posterior branch. The anterior branch distributed parotid gland and the posterior branch distributed auricle. The anterior branch is again divided into superficial branch which is extended to skin and deep branch which enters parotid gland. We classified five types as the branching pattern of the GAN. Type I which is described in textbooks as typical pattern was 21.7%. Type IV where a deep branch arose from the posterior branch was 26.1%. A small branch rose from the deep branch for meeting a trunk of facial nerve. This connection of GAN and facial nerve has observed in all specimens. A histological structure of GAN was observed after excising it from two regions (proximal, distal). The total fascicles areas of both regions were decreased as it moves from proximal region (1.42mm2) to distal region (0.60mm2).

PP-285

Anterolateral retroperitoneal transiliac enstrumentation of the fifth lumbar vertebra: A novel surgical approach.

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High lying lateral iliac crest impedes anterolateral screw placement to the fifth lumbar vertebra. This article describes an antero-lateral approach to L5 vertebra and documents safe zones on iliac crest and lateral surface of L5 vertebra. The aim of the present study was to describe an anterolateral retroperitoneal transiliac (ART) screw placement technique to the fifth lumbar vertebra.

6 formalin fixed cadavers were dissected to describe the external and internal safe zones on iliac bone for burr-hole placement. Lateral surfaces of L5 vertebra were also dissected to describe the safe zones for during screw insertion. An illustrative case of ART instrumentation of L5 vertebra in a high lying LIS was also demonstrated.

Case illustration: Twenty-nine year old man with L4 burst fracture was operated on by anterolateral retroperitoneal (AR) approach. L4 corpectomy and femur shaft allogreft placement, L3-L5 Z-plate instrumentation was performed. During the operation, high lying lateral iliac spine was impeding correct screw insertion to L5 vertebra. A burr hole was placed onto iliac bone to insert screwdriver into L5 in the axial plane that was parallel to end plates.

The results showed that there were safe zones on iliac bone and L5 lumber vertebra. External surface of the iliac bone was covered by gluteus medius muscle. No neural structures were encountered. Internal surface of the iliac bone was covered by iliacus muscle and superior part was safe. The ureter and genitofemoral nerve were lying over and crossing psoas muscle, and they could be mobilised easily. The roots of lumbosacral plexus were far from the lateral surface of lumbar vertebrae.

Anterolateral instrumentation of the fifth lumbar vertebra is difficult if high lying LIS impedes instrumentation. High lying LIS may not allow giving parallel direction to the screw inserter sleve in order to insert screws into body of the fifth lumbar vertebra. In such cases, ART instrumentation of the fifth lumbar vertebra can be possible by opening a burr hole in the LIS.

PP-286

A case of unilateral accessory navicular

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Accessory navicular (cornuate navicular) is one of the most common accessory ossicles in the foot. It is found 4 - 21 % in asymptomatic population. An accessory navicular bone which was encountered at the left foot of a 65 years old male cadaver is reported in this study. Three types of accessory navicular bone have been described. At this case, the ossicle which was fused to the medial side of the parent navicular bone was defined as type III. The tendon of the posterior tibial muscle was inserting on the medial and plantar surface of accessory navicular. These accessory ossicles may be associated with pathologic conditions such as posterior tibial tendon tear and painful navicular syndrome. They also should be taken into account as they can often be confused with fractures at the X-ray films.

PP-287

Bilateral hypoplastic posterior tibial artery

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During the dissection of a 56-year-old male cadaver, it was observed that posterior tibial arteries were bilaterally hypoplastic. The popliteal artery was dividing into two branches as anterior tibial and peroneal arteries at both of the legs. After a short course the peroneal artery was giving off the hypoplastic posterior tibial artery on both sides. The peroneal artery was extending deep to the flexor hallucis longus, coursing to the medial side at the distal part of the leg, and then entering into the tarsal tunnel. While the hypoplastic artery was joining to the peroneal artery at the distal part on the left side, it was terminating at about half of the flexor digitorum longus on the right side. According to Kim et al (1989) this pattern is called as type IA. It is emphasized that to be aware of this kind of variations is important for vascular surgery.