

for the left auricle were performed. Microscopically, the resected specimen consisted of lipoid, fibrous, and connective tissues, with evidence of an inflammatory cellular infiltration. The wound healed by primary intention and the patient was discharged 14 days after operation.

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Nose

Pitanguy, I., Calixto, C. A., and Caldeira, A. M. L. Critical analysis and evolution of secondary rhinoplasties. (Portuguese) *Rev. Bras. Cir.* 74: 40, 1984.

The authors analyzed 604 secondary rhinoplasties divided into two periods: 1957 to 1978 and 1979 to 1982. The importance of precise diagnosis and a waiting period (at least 6 months) to allow for softening of scar tissue are emphasized. Comparing the two groups, a decrease of excessive reduction of the dorsum was observed in the later group, and there was an increase of tip deformities and septal deviations.

Conservative procedures are preferred. Autologous cartilage gives satisfactory results for dorsum increases. Bone grafts were frequently resorbed. Tip alterations are considered more difficult to correct. Current procedures were employed, emphasizing the significance of Pitanguy's ligament in the treatment of the excess of intercrural fibrous tissue. Projection of the tip was achieved either by submucous joining of medial crura and domes or by insertion of a shaped piece of auricular cartilage on the top of the dome. The same technique was used for treating the pinched tip. Removal of the lower septum is seldom used on a dropped tip. Shaping and replacing the alar cartilages must be added to prevent an artificial looking tilt. Flaring or asymmetrical nostrils are repositioned by cautious resection and measured rotation of their lateral aspect.

Héctor Marino

Salivary Glands

Anneroth, G., and Hansen, L. S. Minor salivary gland calculi. A clinical and histopathological study of 49 cases. *Int. J. Oral Surg.* 12: 80, 1983.

Information concerning minor salivary gland stones has been rare in the medical literature. These calculi are very small submucosal nodules (measuring 2 to 15 mm) that are hard or firm and freely movable in the surrounding tissue. They are most often seen in the buccal and upper lip mucosa and are seldom detected in the lower lip and palate.

The authors present 49 cases of salivary gland calculi. Their etiology, pathological changes, and extent of mineralization are discussed.

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Cugadasan, V. Intraoral radiographs in management of sialolithiasis. *Singapore Med. J.* 25: 64, 1984.

Deposition of calcium salts other than in the formation of bone and teeth is considered a pathologic process. Formation of calculus in the salivary glands and ducts is not an uncommon occurrence among persons of middle age. Calculi pres-

ent in the sublingual, submandibular glands and ducts are best demonstrated by use of intraoral occlusal films plus extraoral films. Those that are located in the parotid duct often can be demonstrated clearly on a standard dental film that is placed against the inside of the cheek and extended upward. Roentgenograms made with a short exposure often reveal stones that are not clearly discernible otherwise.

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Goldfarb, A., Nitzan, D. W., and Marmar, Y. Changes in the parotid salivary gland of beta-thalassemia patients to hemosiderin deposits. *Int. J. Oral Surg.* 12: 115, 1983.

The authors describe the pathologic changes and clinical manifestations of iron deposition in the parotid glands of patients having beta-thalassemia. These changes were manifested by swelling and recurrent short attacks of sharp pain in the parotid region and total absence of isotope uptake by these glands. The iron overload of serous cells of the parotid gland is a sequela of this disease and the enormous amounts of blood transfusions that these patients receive during their lifetime.

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Guerrier, Y. Mucoepidermoid tumors and acinic cell tumors of the parotid. *Acta Otorhinolaryngol. Belg.* 36(6): 971, 1983.

Mucoepidermoid and acinic cell carcinoma of the salivary glands are relatively rare and have a tendency to recur locally. They sometimes metastasize to lymph nodes and at a distance. Several cases are presented and the evolution recorded according to therapy.

Norbert Robbe

Bones and Joints

Agus, B., et al. Therapeutic injection of the TMJ. *Oral Surg.* 55: 553, 1983.

Installation of steroids into an acutely inflamed temporomandibular joint is indicated for the patient who is allergic, intolerant, or unresponsive to the usual anti-inflammatory medications. Multiple injections are not advised because of the possibility of accelerated cartilage disintegration. A simplified technique for a therapeutic injection of the temporomandibular joint is presented.

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Boland, T., and Beirne, R. Zygomatic exostosis. *Int. J. Oral Surg.* 12: 124, 1983.

The authors report an unusual extra-articular bone growth that inhibited mandibular movements and could not be detected by conventional radiographic examination. Computed tomography revealed an exostosis, extending from the medial surface of the left zygomatic arch to an enlarged left coronoid process. In a review of the medical literature, only three cases were reported previously.