to the quadratus lumborum (QL) at level of L3 were investigated.

Material and Methods. 60 cadavers (120 sides), embalmed with Thiel´s method, were investigated in supine position. The nerves ventral to the QL were identified and marked with head-coloured pins and dissected carefully to most distal point as possible to determine the nerve according to their innervation area. Results were documented and compared to the nerve courses described in literature.

Results and Discussion. In total, 92 sides were assessable. In 51 cases, branches of the IHN accompanied the SCN as well as the IIN. The IIN and parts of the IHN crossed the QL-block level at L3. The topography of the SCN, IHN and IIN according to literature (entire IHN an IIN emerge together as a trunk), was found in 5 cases only. In 25 cases, the SCN, IHN and IIN crossed the QL separately, solely the IIN at level of L3.

Conclusions. The IIN is the nerve, which will be reached at L3 level for the QLB. Only parts of the IHN will be reached, the SCN is much more cranial.

VARIABILITY OF SUBMENTAL AND SUBLINGUAL ARTERIES IN THE SUBLINGUAL SPACE AND RELATIVE HAEMORRHAGE RISK IN ORAL SURGERY

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Key words: *submental artery, sublingual artery, sublingual space, variation, oral surgery*

Aim. This study aimed to demonstrate the anatomical variations of the submental and sublingual arteries (SA and SLA) in the sublingual space. This region is subjected to various surgical procedures, such as implant placement and tori mandibularis removal, which rarely may lead to extensive haemorrhage.

Material and Methods. A Medline (PubMed) and Science Direct literature search was made regarding the SA and SLA variants along with the severe bleeding complications in oral surgery published in English up until December 2017. Inclusion criteria: cadaveric and clinical studies. Exclusion criteria: patients receiving anticoagulation treatment.

Results and Discussion. The SA is the largest of the four cervical branches arising from the facial artery (FA). However, a distribution from the external carotid artery has also been reported. SA is mainly originated superficially to the submandibular gland or between the superior border of the gland and the body of the mandible. The SLA is given off the lingual artery, the FA and the SA in the anterior border of the hyoglossus muscle. The sublingual space can be supplied by seven different arterial branching patterns. The latter are formed either independently from the SA and the SLA, or their common contribution. The anterior mandible has the largest bleeding susceptibility in the canine area mainly due to lingual cortical plate perforation.

Conclusions. The present study provides precise data on the course of the SA and the SLA in the sublingual space, which will be of clinical importance during oral surgery of the anterior mandible and especially in implant placement.

RETROSPECTIVE EVALUATION OF SOFT TISSUE THICKNESS OF THE TOPOGRAPHIC POINTS IN ADULT POPULATION BY RADIOLOGICAL METHODS

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Key words: *facial soft tissue thicknesses, skeletal classes*

Aim. This study was carried out to determine facial soft tissue thickness (FSTT) of adults according to skeletal class and to detect whether there is a statistical significance between groups.

Material and Methods. The facial soft tissue thickness was measured both manually and digitally considering gender and age groups. The difference between the skeletal classes was compared after the obtained data were classified according to the skeletal classes.

Results and Discussion. In our study, FSTT values of the males were found to be greater than those of the females. There was no significant difference in tissue thickness between the two sexes in glabella and nasion regions. In our study the values of FSTT were examined according to skeletal classes. In the skeletal class 3 group, the values of FSTT in the pogonion area were statistically lower than class 1 and 2 skeletal groups. In women with class 2 jaw structure, FSTT in the pogonion region was found to be significantly greater than those of Class 1 and 3 females. Also, men with class 2 jaw structure had significantly higher FSTT values in the labrale inferior region than those of class 1 and class 3 males.

Conclusions. The FSTT can be affected by various factors such as skeletal class, age, bone structure, race and symmetry of the face.