Surgical protocol of buccal fat pad excision technique for functional and aesthetic purposes: a series of 58 clinical cases

Protocolo cirúrgico da técnica de excisão do corpo adiposo bucal para fins funcionais e estéticos: uma série de 58 casos clínicos

Received: 2023-08-10 | Accepted: 2023-09-10 | Published: 2023-09-15

Tatiana Miranda Deliberador
Instituto Latino Americano de Pesquisa e Ensino Odontológico ILAPEO, Brazil
E-mail: tdeliberador@gmail.com

Claudia Roberta Tenório
Instituto Odontológico das Américas, (IOA) Boutique, Curitiba, Brazil.
E-mail: Odonto_tenorio@hotmail.com

Suyany Gabriely Weiss
Universidade Positivo, Brazil
E-mail: suyanyweiss@hotmail.com

Alexandre Domingues Teixeira Neto
Instituto Odontológico das Américas, (IOA) Boutique, Curitiba, Brazil.
E-mail: alexandre@batelsoho.com

Jeferson Luis de Oliveira Stroparo
Universidade Positivo, Brazil
E-mail: jef_stroparo@hotmail.com

ABSTRACT

There is a limited number of published studies regarding buccal fat pad removal for aesthetic contouring of the midface and lack of patient follow-up. To describe a protocol of bichectomy technique, with aesthetic and functional purposes and to show its predictability with a report of a cases series. The bichectomy described herein was systematically applied in 58 patients. All data was submitted to statistical analysis with a significance level of 0.05. From 58 patients, 89.5% were women. The median age was 35 (19-62) and 64% of the patients had round facial shape. No permanent or significant complications occurred, and all patients declared to be satisfied with aethetics and/or function. There was no difference in the amount of removed tissue from left and right side (p = 0.227), however, the total fat tissue removed is different according to the facial shape (p = 0.022). Round facial shape had a greater amount of tissue removed than the square facial shape (p = 0.03). If this protocol is followed correctly, bichectomy surgery can be performed accurately, safely, and predictably. The amount of tissue removed was equal on both sides with the total fat tissue removed is greater in round facial shapes.

Keywords: Anatomy regional; buccal fat pad; bichectomy; oral surgery.
RESUMO

Há um número limitado de estudos publicados sobre a remoção do corpo adiposo bucal para contorno estético do terço médio da face e falta de acompanhamento do paciente. Descrever um protocolo de técnica de bichectomia, com finalidade estética e funcional e mostrar sua previsibilidade através do relato de uma série de casos. A bichectomia aqui descrita foi aplicada sistematicamente em 58 pacientes. Todos os dados foram submetidos à análise estatística com nível de significância de 0,05. Dos 58 pacientes, 89,5% eram mulheres. A mediana de idade foi de 35 (19-62) anos e 64% dos pacientes apresentavam formato facial redondo. Nenhuma complicação permanente ou significativa ocorreu e todos os pacientes declararam estar satisfeitos com a estética e/ou função. Não houve diferença na quantidade de tecido removido do lado esquerdo e direito (p = 0,227), porém o tecido adiposo total removido é diferente de acordo com o formato facial (p = 0,022). O formato facial redondo teve maior quantidade de tecido removido do que o formato facial quadrado (p = 0,03). Se este protocolo for seguido corretamente, a cirurgia de bichectomia pode ser realizada com precisão, segurança e previsibilidade. A quantidade de tecido removido foi igual em ambos os lados, sendo que o tecido adiposo total removido é maior nos formatos faciais redondos.

Palavras-chave: Anatomia regional; corpo adiposo de bichat; bichectomia; cirurgia oral.

INTRODUÇÃO

The search for dentofacial aesthetics is increasingly in demand in medical and dental offices. The lower contour of the face consists of four elements: the masseter muscle, the subcutaneous fat, the mandibular bone, and the buccal extension of the buccal fat pad (BFP). In facial aesthetics, BFP has an important role in facial modeling, because if the mouth extension is excessive, patients complain about the rounded face due to excess cheeks (DUBIN et al., 1989; TAPIA et al., 2006; THOMAS et al., 2012; XU et al., 2013)

The technique of Bichectomy conceptualized as the surgical removal of the buccal extension of the Buccal fat pad, has as main indication in the area of Dentistry, the elimination of nibbling of the cheek mucosa (morsicatio buccarum) and consequently improving facial aesthetics (MOURA et al., 2018)

MATARASO (1991) was one of the first to describe in the literature the removal of BFP for aesthetic purposes.6 Some reports in the literature show that the removal of BFP allows for predictable results in decreasing the volume of the lower third of the face, in addition to defining the facial contour of the region, making the face more longitudinal and contributing to aesthetics(HONG AND CHEN, 2000; MATARASSO, 2006; WENIGER et al., 2019).

However, even when well indicated, it is a procedure that generates controversy due to the lack of knowledge of the anatomy of the region, as well as the lack of detailed surgical description of the technique, not making it reproducible and safe (ALVAREZ and SIQUEIRA, 2018). There is a limited number of published studies regarding buccal fat pad removal for aesthetic contouring of the midface and lack of patient follow-up or reported post-operative
complications (ALVAREZ and SIQUEIRA, 2018; BENJAMIN and REISH, 2018; STORRER et al., 2019; WENIGER et al., 2019).

Therefore, this paper aims to describe a safe protocol for the surgical technique of Bichectomy, with aesthetic and functional purposes and to show its predictability with a report of a series of 58 clinical cases. Besides, it aims to demonstrated if there is difference in the amount of tissue removed according to the facial side and shape in these cases.

MATERIALS AND METHODS

This study was approved by the local human subject’s ethics board (CAAE 29165120.0.0000.0093) and was conducted in accordance with the Helsinki Declaration of 1975, as revised in 2000. The patients also signed an informed consent form.

Study Design

The technique of intraoral Bichectomy described was applied systematically in a series of 58 cases operated at the surgical center of Universidade Positivo, from 2016 to 2018. The patients included in this series of cases had as main complaint the nibbling of the cheek mucosa and the desire to reduce the cheeks and/or thin the face due to the presence of a very rounded face.

Patients from both sexes, median age of 35 (19-62) years old were submitted to the bichectomy technique, without any other type of surgical intervention, according to the following protocol, developed by the authors:

1) Anamnesis and clinical examination:

Through anamnesis, the professional should ask the patient's main complaint, which should include nibbling of the cheek mucosa and/or dissatisfaction with the shape and/or size of the cheeks.

In the physical examination of extra buccal palpation, the patient's face is positioned in front of the professional to observe the facial biotype. In this same position, the face is also palpated in the extra oral region, between the zygomatic arch and the mandibular branch, to manually locate the buccal extension of the Buccal fat pad. The professional should assess the region, asking the patient to keep their lips open and their facial muscles relaxed. On palpation, if the cheek is more floating and softer, it defines the excess fat to be removed. This examination should also be done by asking the patient to clench his teeth, to assess whether there is hypertrophy in the region of the masseter muscle. In this palpation, if the cheek has a firmer consistency, it is faced with the presence of the anterior prominence of the masseter muscle and not with the excess of BFP, which contraindicates the surgical technique of Bichectomy.
In the intraoral clinical examination, the cheek is palpated and it is important to observe the presence of the linea alba, which is a white line usually bilateral at the level of the occlusal plane of the teeth associated with pressure, irritation by friction, or trauma by suction of the mucosa, between the buccal surfaces of the teeth.

If the patient has nibbling of the cheek mucosa, regardless of the type of face or the presence of masseter muscle hypertrophy, the Bichectomy technique is indicated. The most suitable types of faces are the round and oval faces, and these are the ones that respond most to the aesthetic point of view.

2) Preoperative exams:

Preoperative exams are essential for good surgical management for both patient and clinicians. Complete blood count, complete coagulogram and fasting blood glucose tests are mandatory. The patient should only be submitted to surgery when all results are within normal parameters.

3) Facial photography:

A series of standardized photos are needed to compare the pre and postoperative periods. Five pictures are taken: the first with the patient's face facing forward with the chin parallel to the ground, without smiling (Figure 1A), the second with the patient smiling (Figure 1B). The patient with a face turned at 45 degrees, with chin parallel to the ground, to the right side without smiling (3rd) and smiling (4th) (Figures 1C and 4D) and to the left side without smiling (5th) and smiling (6th) (Figures 1E and F). In the 7th picture, the patient positions the chin angled upwards and the picture is taken in the chin-forehead direction (Figure 1G).
4) Preoperative medication:

Patients are previously instructed in surgery to take 4.0 mg dexamethasone (02 tablets, one hour before the procedure), usually prescribed in a single dose.

5) Surgical Technique

To make it more didactic, the surgical technique was divided into topics. But before starting the surgical procedure, the following instruments and materials selected for this protocol are: Disposable surgical drape kit and disposable sucker, clinical kit (mirror, forceps, explorer probe, carpule, scalpel handle, two curved and two straight hemostatic forceps, goldman fox scissors, needle holder, Dietrich forceps, tub, minesota retractor, two syringes disposable 10ml, sterile gauze, needle for anesthesia, scalpel blade Nº. 15, topical anesthetic, injectable anesthetic: mepivacaine or articaine, 4.0 silk suture thread, micropore.
a) Asepsis: Asepsis was performed extra orally with iodopovedine (Figure 2A) or 0.12% chlorhexidine digluconate and intra oral with 0.12% chlorhexidine digluconate. In intra-oral asepsis the mouthwash must be for exactly 01 minutes so that the mouthwash really has its antibacterial effect, minimizing the risk of bacteria penetrating the cavity during the trans-surgical procedure.

b) Positioning of the Patient: In the dental chair, the patient is in the supine position with the headrest at 45 degrees, so that the buccal portion of the bicolor ball "falls" more inferiorly, getting closer to the incision.

c) Anesthesia: Anesthesia is performed on the upper posterior alveolar nerve (Figure 2B) and infiltrative anesthesia in the molar region (Figure 2C) and upper premolar with 2% mepivacaine hydrochloride with vasoconstrictor (epinephrine) or 4% articaine hydrochloride with epinephrine 1: 1000.

d) Incision: The secret of this technique is to make the incision in the correct place (Figure 2D). Therefore, before the incision, the exit of the parotid duct is in the jugal mucosa. With the aid of the Minnessota retractor, the duct outlet is protected (Figure 2E), and the instrument allows the visualization of the area to be incised, since the Minnessota must be about 10mm away from the maxilla (Figure 2E). In the direction of the distal of the 2nd molar, about 4 to 5 mm from the maxillary ridge (this distance facilitates the suture) the scalpel blade n. 15 should be positioned at 45° with the same facing towards the ear (Figure 2F). The incision is made above the exit of the duct from the parotid.

Figure 2: Surgical procedures. A – Extra orally asepsis with iodopovedine. B –Anesthesia performed on the upper posterior alveolar nerve. C – Infiltrative anesthesia in the molar region. D – Identification with the periodontal probe of the exit of the duct of the parotid. E – The exit of the duct of the parotid protected by the Minnesota retractor. F – The blade n. 15 should be positioned at 45° with the same facing towards the ear.
The punctual incision is made by penetrating the entire active tip of the blade (Figure 3A). Initially there will be some resistance, and the professional must continue to deepen the blade until he feels a “falling sensation” which means that the connective tissue capsule that encapsulates the Buccal fat pad was broken. After the blade falls into a void, the blade should be retracted slightly (remove from depth) and widen the incision that should be parallel to the maxilla, from the distal of the 2nd molar to the mesial of the 1st molar or distal of the 2nd premolar (Figure 3B). Important: In this punctual (or puncture) incision, the cheek mucosa, the buccinator muscle and connective tissue capsule are broken. If the connective tissue capsule is not broken, the Buccal fat pad will not be exposed. It is particularly important for the professional to know in detail the anatomy of the region.

e) Divulsion: With the aid of hemostatic forceps, the divulsion is performed. The hemostatic forceps must enter closed between the connective tissue capsule and the fatty tissue and be opened to enlarge the capsule rupture (Figure 3C and D). This divulsion should be done around all the fatty tissue. Divulsion is mandatory so that the tissue can be removed easily, without tension (Figure 3E). Then, with the aid of the hemostatic forceps or Dietrich forceps, the professional clamps the fatty tissue so that it is removed.

f) Removal of the BFP: After dividing the tissues, the BFP tends to “come out” of the cavity with ease, if the fatty tissue is not seen, it is necessary to apply pressure on the cheeks from the bottom up. The fatty tissue that comes out of the cavity, which is yellowish in color, is clamped and with delicate circular movements, it is pulled out (Figure 3E). To assist in removal, intra and extra-oral cheek movements are performed from jaw to maxilla, as if “pushing” the cheek from the bottom up. In most cases, the buccal portion of the Buccal fat pad is removed entirely (Figure 3F and G)
Figure 3: Surgical procedure. A – The punctual incision is made by penetrating the entire active tip of the blade. B – After the punctual incision, an incision is made parallel to the maxilla from the distal of the 2nd molar to the mesial of the 1st molar or distal of the 2nd premolar. C and D – Before pulling the bichat ball, the divulsion must be performed hemostatic forceps must enter closed between the connective tissue capsule and the fatty tissue and be opened to enlarge the capsule rupture. E – After divulsion, adipose tissue tends to leave its bed without tension. F – With delicate circular movements adipose tissue should go without tension being removed. G – Ideally, the adipose tissue should be removed entirely.

Source: Autores (2023)

Instruments should never be placed inside the cavity. A common question is: "Has the entire mouth portion been removed?" One tip is that when the buccal portion is almost completely removed, it tapers close to the jugal mucosa (Figure 4A), decreases in size, and generally the patients feel a tingle, which means that the masseter muscle is being pulled. It is a common clinical observation. Before going for a suture, the professional should investigate the region with intra- and extra-oral palpation and/or placing the tip of the sucker in the cavity to make sure that the entire buccal portion has been removed. There may be a small remnant of fatty tissue (Figure 4B) that needs to be clamped and pinched out of the cavity. At the end, an empty cavity is observed, and the masseter muscle can often be seen (Figure 4C). After removing the adipose tissue, it should be placed immediately in a 10- or 20-ml syringe to count how many ml of fat left each side (Figure 4D). Usually the values are the same or similar. There cannot be a large discrepancy in the quantity in ml between the sides.

g) Suture: After the removal of the fatty tissue, an inspection is carried out to ascertain the local hemostasis, and subsequently an average of four to seven simple sutures is performed with 4.0 silk thread. The sutures should be close to each other to prevent food from entering (Figure 4E).

Obs. It is recommended to conclude the surgery on one side and then start the surgery on the opposite side. Tip: never start surgery on the opposite side without first suturing the operated side. The sooner the suture is done, the less air enters the cavity and the less edema the patient will have. Note in the patient's medical record which side was operated on by 1st, the amount of fat that left each side and if there was any complication during the trans-surgical procedure (such
as increased bleeding on one side). This information may be valid in the postoperative follow-up because the side that was operated on by the 1st and that had more bleeding generally has more postoperative edema.

6) Immediate postoperative: Clinically assess the patient (Figure 4F) and perform a facial bandage (Figure 4G). Facial bandaging can be done with micropore or compression tape, as long as the patient's face is tight, this helps to minimize edema. Patients are medicated with analgesic (paracetamol 750mg every 06 hours for 03 days), anti-inflammatory (according to the choice of each professional) and antibiotic (Amoxicillin 500mg + Potassium Clavulanate 125mg every 12 hours for 07 days). The mouthwash with 0.12% chlorhexidine is mandatory until the sutures are removed. Between 7 to 10 days, suture removal is recommended, and the first post-surgical photos are taken.

7) Postoperative recommendations:

The patients received instructions to make intermittent cold compresses on the face for 4 to 6 hours and absolute rest for 48 hours. They should not remove the bandage performed after surgery for 48 hours, and liquid, pasty and cold food was indicated for 48 hours. It is particularly important that the patient do not eat foods with grains and/or granules. The first facial lymphatic drainage should be performed after 48 hours, and physical activities or exposure to the sun should be avoided for 03 weeks.

8) Postoperative follow-up:
Follow-ups are made with 30 (Figure 5 A, B, C, D, E), 60, 90 (Figure 5F), and 180 days, and in all follow ups the same series of initial photos are taken and palpation is performed intra and extra buccal to check for signs of local fibrosis and/or seroma.

Figure 5: Follow-up with 30 days postoperative. A – Face facing forward with the chin parallel to the ground without smiling, B – Face facing forward with the chin parallel to the ground with smiling, C – Face turned at 45 degrees with chin parallel to the ground, to the right side without smiling, D – Face turned at 45 degrees with chin parallel to the ground, to the left side without smiling, E – The patient positions the chin angled upwards and the picture is taken in the chin-forehead direction. F – Follow-up with 90 days postoperative.

Source: Autores (2023)

9) Possible postoperative complications:
Among the possible postoperative complications, the most severe risk is facial paralysis. Furthermore, numbness of the face may occur, due to facial nerve ramifications, emphysema,
which is the entry of air into the tissues just under the skin, intense facial edema, hard face due to abscess, ruptured, crushed or manipulated parotid duct, fever and infection.

Statistical analysis

The results were submitted to descriptive and statistical analysis. To assess the normality of the data, the Shapiro Wilk test was used. To perform the comparison between the groups, Kruskall Wallis and Mann Whitney tests were performed. All analysis were performed with a significance level of 0.05 in the Statistical Package for Social Science Software (SPSS 25.0).

RESULTS

Fifty-eight patients, of both sexes, aged 35 (19-62) were included in this study. Sixty-four percent of the patients had round facial shape, and the median of the total fat tissue removed from the right and left side was 6.9 (4-10). All descriptive data can be seen in Table I.

Table I. Variables of the study

<table>
<thead>
<tr>
<th>Variable</th>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Median (min-max)</td>
<td>35 (19-62)</td>
</tr>
<tr>
<td>Gender</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>51 (89.5)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6 (10.5)</td>
<td></td>
</tr>
<tr>
<td>Face shape</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>Oval</td>
<td>11 (19.3)</td>
<td></td>
</tr>
<tr>
<td>Round</td>
<td>37 (64.9)</td>
<td></td>
</tr>
<tr>
<td>Square</td>
<td>9 (15.8)</td>
<td></td>
</tr>
<tr>
<td>Fat tissue (mL)</td>
<td>Median (min-max)</td>
<td></td>
</tr>
<tr>
<td>Right side</td>
<td>3.5 (2.2-5.1)</td>
<td></td>
</tr>
<tr>
<td>Left side</td>
<td>3.2 (2-5.1)</td>
<td></td>
</tr>
<tr>
<td>Both sides</td>
<td>6.9 (4-10)</td>
<td></td>
</tr>
</tbody>
</table>

Shapiro Wilk, p > 0.05

Source: Autores (2023)

No postoperative complications were observed, and all patients were satisfied with the functional (100% elimination of nibbling of the cheek mucosa) and aesthetic results.
When comparing the amount of removed tissue from left and right side, no difference was obtained ($p = 0.227$), however, the total fat tissue removed is different according to the facial shape ($p = 0.022$). Round facial shape had a greater amount of tissue removed than the square facial shape ($p = 0.03$). No difference was found between age and sex and facial profile ($p > 0.05$). The comparison between facial shape and fat tissue can be seen in Table II.

Table II. Buccal fat removal and facial shape

<table>
<thead>
<tr>
<th>Face Shape</th>
<th>Median (min-max)</th>
<th>$P$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oval</td>
<td>6.1 (4.8-7.5)$^{ab}$</td>
<td></td>
</tr>
<tr>
<td>Round</td>
<td>7.5 (5.5-10)$^b$</td>
<td>0.028</td>
</tr>
<tr>
<td>Square</td>
<td>5.6 (4.4-9.8)$^a$</td>
<td></td>
</tr>
</tbody>
</table>

Kruskall Wallis test. Different letters demonstrate statistically significant difference: Mann Whitney test $p = 0.03$

Source: Autores (2023)

**DISCUSSION**

Anatomically, the Buccal fat pad is a fatty, encapsulated, and specialized tissue, its volume varies throughout life (approximately 10 cm$^3$), being different from subcutaneous fat. It fills deep spaces in the tissue, providing cushioning when the masticatory and mimetic muscles contract. In addition, it cushions important structures of the forces generated by muscle contraction (TIDEMAN et al., 1986; DUBIN et al., 1989; STUZIN et al., 1990). It is delimited by the buccinator, masseter, ascending mandibular ramus and zygomatic arch muscles (KHIABANI et al., 2014) It is attached by 6 ligaments to the maxilla, posterior zygoma, internal and external borders of the infraorbital fissure, temporal tendon and buccinator membrane (TIDEMAN et al., 1986; DUBIN et al., 1989; JACKSON, 2003). It has a body with 4 main processes, divided into buccal, pterygoid, pterygopalatine and temporal portion. The buccal portion (BFP) corresponds to 50% of the Buccal fat pad (ZHANG et al., 2002; KABLAN et al., 2015). According to BAUMANN and EWERS (2000), the Buccal fat pad has three sources of irrigation: maxillary artery, superficial temporal artery, and facial artery. In the intermediate plane, the adipose body of the cheek is related to the facial nerve and parotid duct (XU and YU, 2013).

BFP has a very important role in facial aesthetics, because when in excess, it can result in more prominent cheeks, rounded face or pseudo-hernias (MATARASSO, 2006), in addition to interfering with chewing, traumatizing the cheek mucosa with evident signs on clinical intra-
oral examination. Since Egyedi used BFP in a pedicled way to close an oronasal fistula in 1977, it has been widely used as an alternative method (KIM et al., 2008). The performance of bichectomy for aesthetic purposes has been reported for a long time by several authors, having been carried out mainly with the aim of fine-tuning the facial middle third, outlining and enhancing the bone angulations of the zygomatic region, contributing to a more pleasant facial aesthetics (STEVÃO, 2015; ALVAREZ and SIQUEIRA, 2018) possibly motivated by changes in current aesthetic standards.

The ideal candidate for bichectomy should have prominent cheekbones and well-defined jaws, with full cheeks due to the excessive presence of the adipose body (MATARASSO, 1991). Also be over 18, physically healthy, non-smoker and realistic about the goals and results that can be achieved with surgery. The results tend to fluctuate due to the variable volume of the anatomy of the face and the fat of each individual. It is important that the surgeon fully explain to the patient the different issues related to this surgery, such as what the procedure can and cannot treat (expectation), inherent risks, costs and other related factors, such as bleeding and possible cheek infection (JACKSON, 2003; STEVAO, 2015).

Even when properly indicated, it is still a controversial procedure, since it does not have a surgical technique systematized in the current literature, aiming to make it safe and reproducible, in view of the intricate and challenging anatomy of the region (ALVAREZ and SIQUEIRA, 2018) thus emphasizing the importance of this surgical protocol. It is interesting to note that in the present case series, 100% of patients reported aesthetic and/or functional satisfaction with the surgery.

Surgery to remove the bicolor ball can be performed using an intraoral approach or a facial approach during a plastic surgery procedure on the face under general anesthesia. According to the literature, the safest method is through an intraoral incision, as mentioned in the study by KHIABANI et al. (2014) and in the protocol described here. During the procedure of removal of the buccal adipose body, either by intra or extra-oral approach, the adipose tissue must be apprehended and stretched to be excised. Even assuming careful manipulation, injury to the buccal branch of the facial nerve can be almost inevitable in 26.3% of cases of total removal (KIM et al., 2008). In our cases, no complication was observed. Nevertheless, surgical skills and knowledge of anatomy are mandatory to perform this protocol in an accurate way. The surgeon must be careful with the vascular pedicle, parotid duct, and the facial nerve. It is also important to consider the buccal extension of the BFP can pseudohermiate in the aging face (SUREK et al., 2021).

Our protocol demonstrated that surgical reduction of the Buccal fat pad can be efficiently performed with low morbity if the clinician knows the anatomy of the region well. This technique may therefore be considered for aesthetics and functional treatment. However, longer-term
follow-ups would be beneficial in evaluating all outcomes, especially applying validated questionnaires to evaluate patient satisfaction and quality of life. Moreover, our study contains a majority of women, and considering the higher demand for aesthetics coming from men, studies should seek for anatomical and perspectives differences.

CONCLUSION

If this protocol is followed correctly, bichectomy surgery can be performed accurately, safely, and predictably. However, one must always pay attention to the local anatomical region and its precise indication. It was also possible to observe that the total amount of removed tissue (Buccal fat pad) are the same for the right and left sides. However, the total fat tissue removed is greater in round facial shapes.

REFERENCES


