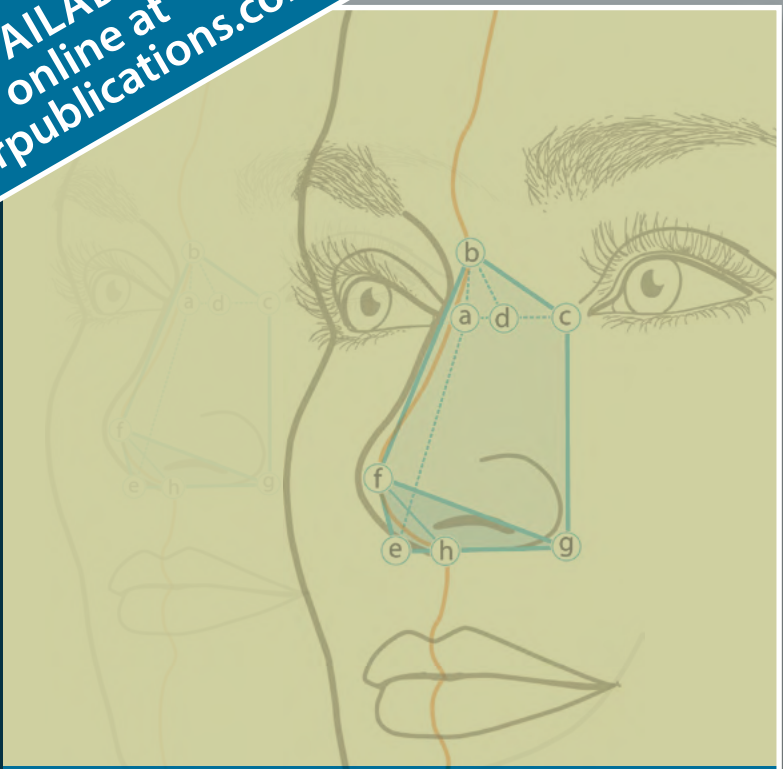
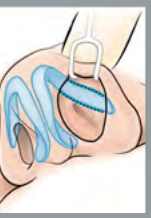
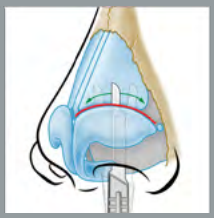
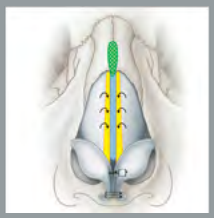
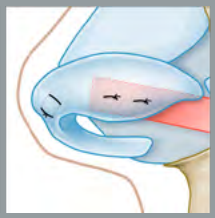
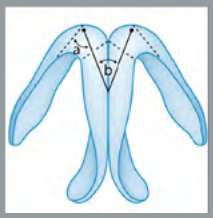


ADVANCED CAUCASIAN AND MEDITERRANEAN RHINOPLASTY

Peter JFM Lohuis

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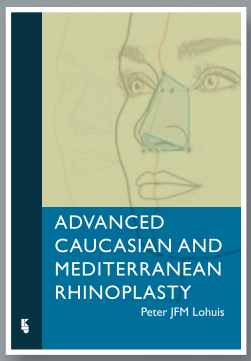


"I know of no other book that considers and describes in such exceptional detail about topics such as the rhinoplasty learning curve, the Utrecht questionnaire, and special problems. When I reviewed the references, I can see that the author has done an extensive amount of reading and collated a tremendous amount of valuable information into the book. It has been clearly, concisely and beautifully presented, not just in the form of the photographs, diagrams and graphics, but in its intellectual integrity and clarity. It is one of the most valuable rhinoplasty textbooks that I have had the privilege to read."

Peter A. Adamson, MD, FRCSC, FACS
Past president of the American Academy of Facial Plastic and Reconstructive Surgery

"Peter Lohuis is one of the rising stars or European and World facial plastics and it thus stands to reason that any tome that he publishes will be a very considered piece of work, with a lot of thought put into the detail. This book delivers exactly that, a thought provoking take on rhinoplasty."

Simon Watts FRCS (ORL HNS) Brighton UK

"In addition to clarity and conciseness, the book has the advantage of being authored by a single surgeon who is well-experienced in functional and aesthetic rhinoplasty. This provides continuity of terminology and concepts. This textbook should prove to be a valuable reference and informative surgical guide for any surgeon performing rhinoplasty."

Professor Shan R. Baker
Past president of the American Board of Facial Plastic and Reconstructive Surgery

2.12 Local and general anesthesia

A. The key to good anesthesia is comfort, safety and structured communication between the surgeon and the anesthesiologist.

B. All my rhinoplasty patients are operated under general anesthesia resulting in complete amnesia, analgesia, and sedation. Complementary topical and local infiltration anesthetics deliver analgesia and vasoconstriction and result in a more or less 'dry' operating field.

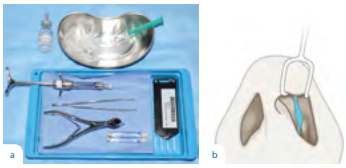


Fig. 4. The tray used for local anesthesia with Xylocaine 1% with 1:100.000 epinephrine and a topically applied cocaine solution (a). Exposure as it is obtained densing infiltration using a 10-mm skin hook or a speculum (b).

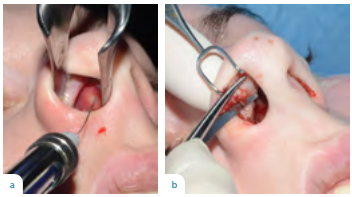


Fig. 5. A 27-gauge needle on a dentist syringe is very helpful for the deposition of local anesthetic agent in the submucoperichondrial plane of the septum and in the incision lines (a). Vibrissae are cut preoperatively with a dull pointed scissor for maximum visualization during surgery (b).

3.8 Rhinoplasty: a play of shadow and light

A. Awareness of the aesthetic subunit principle can be a powerful accelerator of the rhinoplasty learning curve (Fig. 12). A detailed analysis of nasal subunits based on intrinsic contour configurations and the psychology of perception has been provided in detail by Burget and Menick.

The nose has multiple, well-defined, aesthetic units with distinct contour, colour, consistency, sebaceous content, texture and function. In nasal reconstruction, suture lines should rest in the lines between the subunits to avoid being conspicuous. Ideally the entire subunit is resurfaced to minimize color and texture changes.

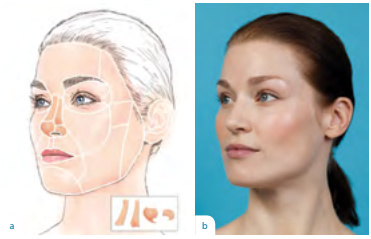


Fig. 12. Aesthetic subunit principal displayed.

B. The surface of the nose is crossed by shallow ridges and valleys that separate it into slightly convex or slightly surfaces: the tip, the columella, the dorsum, paired sidewalls, alar lobules, and soft triangles. Light is reflected on these different surfaces with a different intensity creating patterns of shadow and light which are transported to the retina and transmitted as an electrical impulse to the brain (Fig. 13).

C. How we consciously 'see' the nose also depends on how complex mental processes influence our conscious mental perception. We 'see' color, texture, and contour changes. The absence of a feature unit can 'surprise' the eye and causes it to stop in its normal unconscious scanning pattern to focus on the 'unexpected'.

and extensive septal tunnelling on both sides, the connection between the medial crura and the caudal septum becomes compromised in a similar fashion as with transfixion.

D. The incisions frequently used in rhinoplasty are listed on the next page, together with their indications.

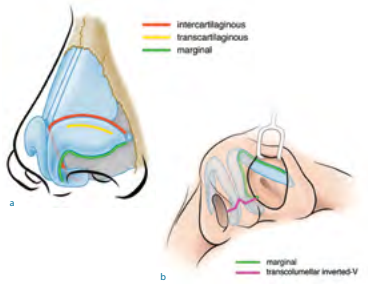


Fig. 28. Several incisions to gain exposure of dorsum, septum and alar cartilages. Endonasal approach (a) and external approach (b).

INCISION	INDICATION
Caudal septum incision (hemitransfixion)	Septoplasty, endonasal approach
Transfixion incision	Deprojection, endonasal approach
Intercartilaginous incision	Endonasal approach
Vestibular incision	Osteotomies
Infracartilaginous incision	Delivery technique, external approach
Transcolumellar inverted-V incision	External approach
V-incision columellar base	Cleft lip deformity
Transcartilaginous incision	Combines cephalic rim resection and intercartilaginous approach

5.3 The scar in the open approach

A. Disadvantages of the external approach include the transcolumellar scar. Several investigations have proven the transcolumellar scar to be more of an issue for the surgeon than for the patient. When care is taken to close the incision without subcutaneous tension and with careful eversion and adaptation of skin edges, the transcolumellar scar is hardly visible and of minor significance in the majority of patients (Fig. 3A). Sometimes up to seven or eight 6-0 nylon sutures can be required to divide the skin over the line of incision.

B. The broken transcolumellar incision is connected to both infracartilaginous incisions. The transcolumellar incision follows the relaxed skin tension line, but is broken up to enhance camouflage and prevent scar retraction. The position of the transcolumellar scar is critical to the end result and should be placed in the middle between the most cephalic part of the nostril and the beginning of the diverging footplates of the medial crura (Fig. 3B). Placing the scar to close to the medial crura might lead to scar retraction and step-off deformity.

Fig. 3A. Careful eversion and adaptation of skin edges using sometimes up to seven or nine 6-0 nylon sutures (a) will leave the transcolumellar scar hardly visible and of minor significance in the majority of patients (b).

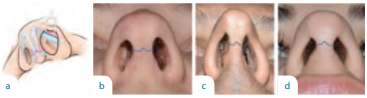


Fig. 3B. The position of the transcolumellar scar is critical for the end result and should be placed in the middle between the most cephalic point of the nostrils and the point where the medial crural footplates start diverging.

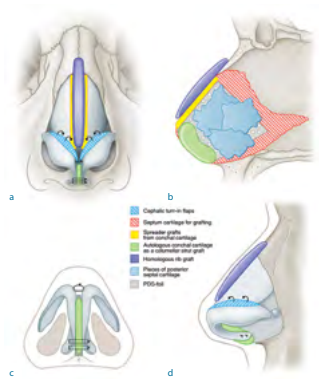
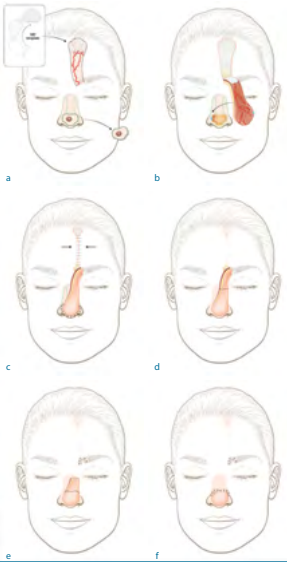


Fig. 3. Surgical steps.

Surgical steps

- External approach
- Transalar septal tunneling
- Harvesting of conchal cartilage
- Harvesting the remaining pieces of posterior septal cartilage
- Septal reconstruction using PDS-foil as a template
- Spreader grafts from conchal cartilage are sutured to the reconstructed septum to widen and strengthen the nasal dorsum
- Autologous conchal cartilage at the base of the template serves as a columellar strut graft
- Cephalic turn-in flap to strengthen the lateral crus
- Tongue-in-groove technique to stretch the medial crura and correct the columellar retraction
- Interdomal suture
- Homologous rib graft or dorsal onlay to create volume



Case study 10

Major deformity
Crooked nose.

Minor deformity
Overprojected tip, dorsal hump, ptotic tip.

History
This 27-year-old man wanted to have something done about his large, crooked nose. Also, his breathing was bilaterally impaired.

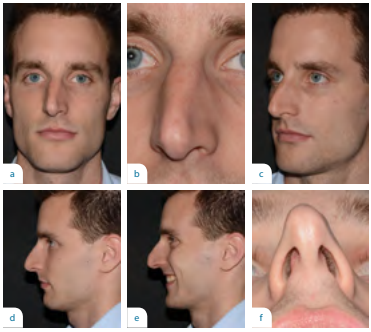


Fig. 1. Preoperative photos of the patient.

Analysis of preoperative photos
The strong, squared features in the face of this male patient are completely distracted by a crooked, overprojected nose. In the basal view, note the slitlike nares of this 'tension nose' and how much anteriorly the medial crural footplates are positioned as a result of the excessive outgrowth of the nasal spina.

Intraoperative photos

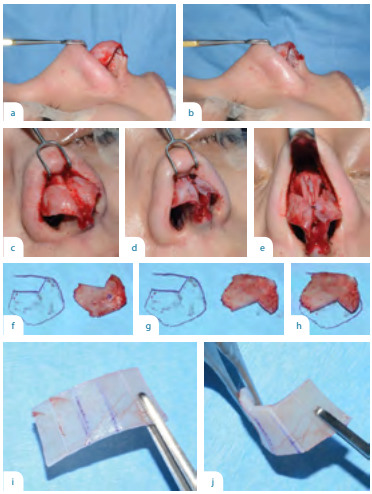
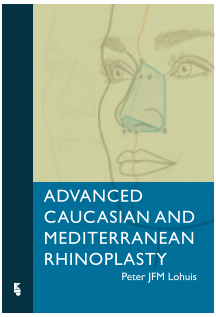


Fig. 4. The ptotic tip (a, c) is refined and upwardly rotated with tips sutures and tongue-in-groove technique (b, d). The nasal dorsum (e) is corrected by subtotal extracorporeal septoplasty transformed into a left-sided spreader graft (f, g, h). A small piece of cartilage is longitudinally incised and used as a radix graft (i, j).



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