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RESEARCH ARTICLE

RHINOPLASTY IN A REMOTE CENTRE

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ABSTRACT

The operation of rhinoplasty in a remote Centre is always not based on aesthetic purposes, but related to the correction of septum to provide a proper airway. This is an account of septorhinoplasty done and the achieved results in our setup, a remote township of tamilnadu down south of India.

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INTRODUCTION

A knowledge of nasal plastic surgery is necessary for otorhinolaryngologist as variations in the external nasal shape are frequently associated with septal deformation. In such cases, correction of the septum can be combined with rhinoplasty. However, rhinoplasty is the branch of surgery where error related to lack of judgement are very obvious. We decided upon septorhnioplasty for the young patients who had airway problems with nasal deformity following trauma and corrected both the airway and the external deformity for the patients.

Surgical Approach and Technique

The first patient, had a dorsal hump and saddling and a twisted septal cartilage. An inverted V shaped incision made over the columella and it was extended to the rim the alar cartilage. The subperichondrial flap was elevated upto the root of the nose. We did an augmentation and reduction rhinoplasty with septal correction for the patient. The other three patients had a dorsal hump and a reduction rhinoplasty was done for them. The other patient was a small boy who had cleft lip and cleft palate corrected and the alar cartilage was double folded into the left nostril and the columella was found to be rudimentary. The inverted V shape incision was made at the base of the columella and the incision was extended rim of the lower lateral cartilage. The subperichondrial flap was elevated upto the level of nasal bone.

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The right side medial crura was released and the foot end of excess cartilage was refashioned and an extended nares was created of the left side and columella was lengthened with the harvested septal cartilage. It was planned to have an aesthetic correction after the boy attained adulthood. Once the nasal passage was widened, we found a rhinolith inside the left nasal cavity and the same was removed. we had another patient with nasal valve collapse on inspiration due to an excess lower lateral cartilage on both sides and he was suffering chronic hypoxia and habitual sniffing. Here again same incision made and flap elevated, excess cartilage removed and remaining cartilage was used to reconstruct the valve via domal suturing. The results were fantastic and the patient was really thankful after the surgery.

DISCUSSION

The modern era of rhinoplasty as we know today began in 1898 with the work, not of an ENT surgeon but an orthopedic surgeon from Berlin, named Jacque Joseph. He was not a very popular surgeon among his colleagues but had contributed a great deal to the technique of rhinoplasty. He described in detail reduction rhinoplasty for the hump and other specific deformities. He particularly drew attention to the social and psychological factors to be taken into consideration prior to rhinoplasty. He also designed several instruments, which are being used today. He published a paper on surgical correction of the nose in great detail and established intranasal rhinoplasty in Europe on a scientific basis at the turn of the 20th Century. He also published a comprehensive book on rhinoplasty in 1928.

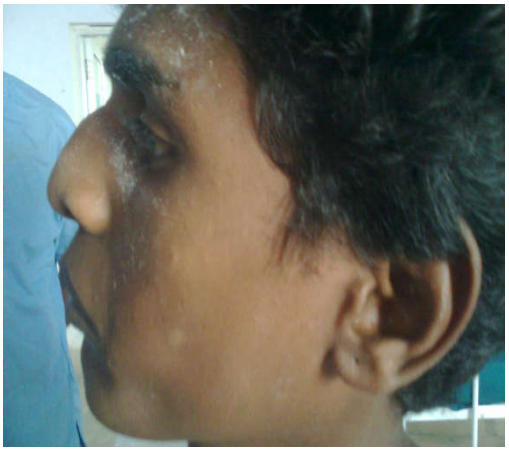


Figure 1. case 1 preoperative picture

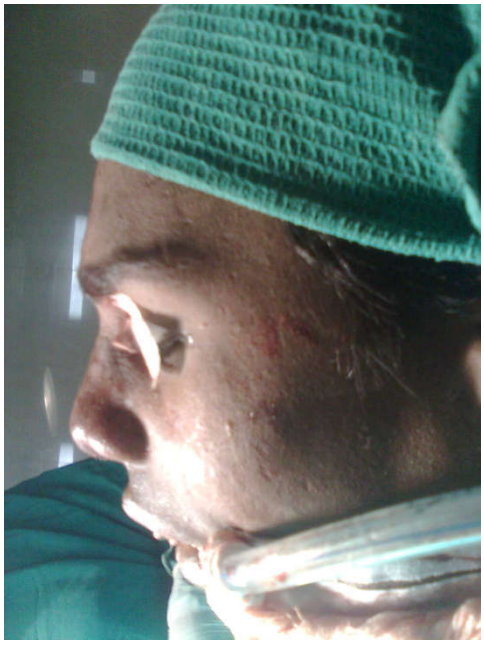


Figure 2. Case 1 postoperative picture

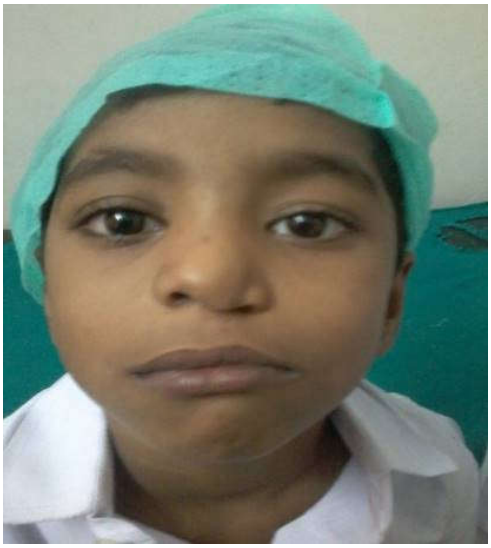
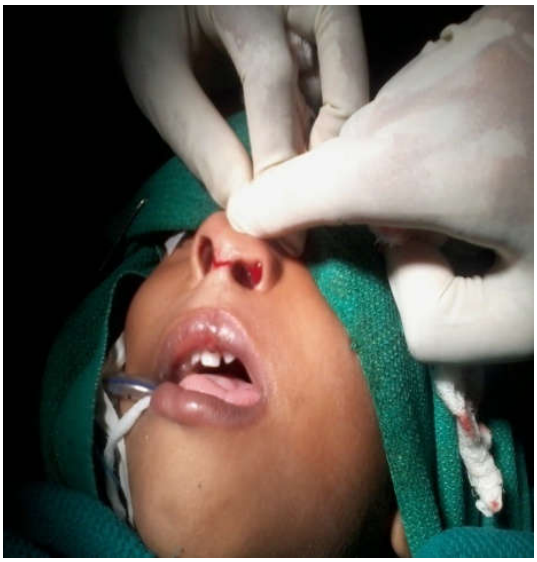


Figure 3. Case 2 preoperative picture

At the same time John Roe in New York continue to perform corrective rather than reconstructive surgery and popularised intercartilaginous approach to the bulbous tip. The degree to which the height and length of the nasal tip can be increased and maintained to enhance the aesthetic quality of the nose is surely one of the major challenges and concerns for plastic surgeons. Furthermore, since the naturalness of the nasal tip must not be damaged, surgeons apply various methods using autologous materials to solve this problem. Unlike Caucasians, East Asians undergo more operations extending the height and length of the nose than operations to reduce the size of the nose.



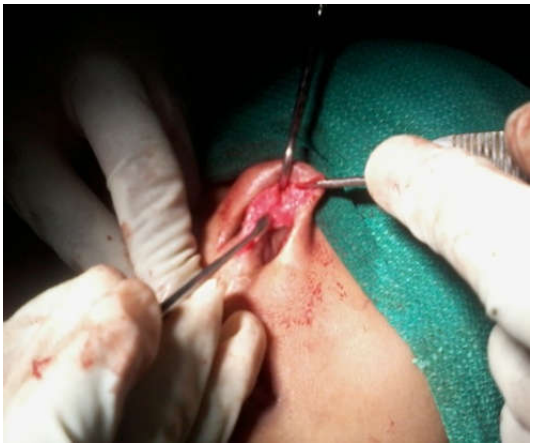


Figure 4: case 2 intraoperative picture

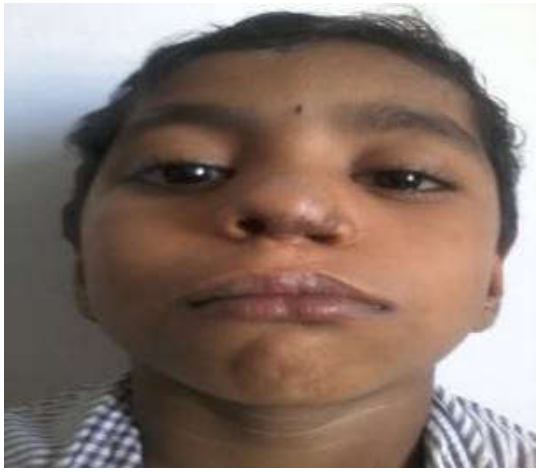


Figure 5: Case 2 postoperative picture

The extension of East Asians' noses requires the sufficient release of soft tissue and an adequate supporting cartilage framework.

The septal extension graft is a very suitable method to extend and maintain the thick skin of Asians' noses since it provides a direct extension of the framework along while maintaining strong support. The correction of a crooked nose still remains a challenge. The natural force existing in the cartilaginous structures and soft tissue continue to act on the nose submitted to rhinoplasty and makes it difficult to achieve an excellent result in the postoperative time. Another factor which may cause the nose to return to its crooked shape is the incomplete correction of the deviated nasal septum. Although, often times the procedure may be considered a success by the surgeon, the patient may feel not pleased with it, and the opposite is also true. Therefore, it is important for the surgeon to understand the patient's complaints, and to analyze the proportions and relationships between the nose and the face through physical exam and photographic documentation.

Conclusion

It is to emphasis that rhinoplasty is not an aesthetic surgery but an essential surgery for patients like the above mentioned. Hence it is imperative, we otorhinolaryngologists starts wielding our expertise to the benefit of the remote villagers.

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Crooked nose: outcome evaluations in rhinoplasty

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Rhinoplasty - A History of Creativity

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Effective Septal Extension Graft for Asian Rhinoplasty

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