

CORRECTIVE RHINOPLASTY WITH SMR OR SEPTOPLASTY— A COMBINED APPROACH

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The nose is a very important part of our anatomy and lest we forget our physiology as well. An ideally shaped nose cannot compensate for poor function, nor is it justifiable to improve function and disregard its aesthetic shortcomings.

A one-stage procedure to improve function and correct nasal deformity at the same time is a logical development. It is not a new concept, nor has it been untried but it is still quite unpopular in India (Gilchrist 1974, Patterson 1966, Edwards 1975). Possibly this is because of the difficulties in its execution, probably because a single surgeon, E.N.T. or plastic, is generally not proficient enough to do both procedures with equal ease.

This article is based on our experience with 25 cases treated by the combined procedure. It is of particular interest because all the patients initially presented with symptoms related to nasal obstruction and were first seen by the E.N.T. surgeon. All these patients also had an obvious nasal deformity and hence were referred to the plastic surgeon with a view towards a one stage correction (Fig. 1). The option of whether or not to combine a corrective rhinoplasty with septal surgery was given to the patient, care being taken to present all the pros and cons of the combined procedure. Many of these patients had already considered

cosmetic correction but had not sought medical advice because of the fear of ridicule. These patients were most enthusiastic about the corrective aspect, the airway problem paling into insignificance.

None of the patients were referred to the psychiatrist for evaluation because none appeared to have a psychological problem. All the patients had nasal obstruction and post nasal discharge of long standing. About half of them also complained of headaches and mouth breathing. The nasal deformity varied but the majority of cases had deviation of the nose and a hump as well (Fig. 2).

Procedure

The operation was undertaken after it was established that there was no sinusitis or nasal infection. In a third of the cases, the maxillary antrum was punctured and a wash-out given to clear the infection.

The operation from choice is performed under local anaesthesia because of the substantial reduction in bleeding. It is conducted in a definite sequence; to vary this sequence to suit one surgeon is dangerous and hence a genuine understanding between the two surgeons is of paramount importance. The alar cartilages are reduced first through an intracartilagenous incision, followed by hump reduction and nasal shortening. After the plastic surgeon is satisfied with the

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shape of the nose in profile, the E.N.T. Surgeon undertakes the SMR or septoplasty. The choice of procedure depends on the type and degree of deviation (Maran 1974, Gilchrist 1974, Edwards 1975). Posterior deviations are best treated with SMR, anterior curvatures with a septoplasty. In all cases the vomerine ridge and the maxillary crest was removed adequately to permit the septum to hang down vertically.

The SMR or septoplasty is done through a verticle incision made atleast one centimeter posterior to the columella incision (Fig. 3). Thus the nutrition of the caudal strut of septal cartilage is not interfered with and there can be no late absorption with subsequent collapse of the tip. Once the airway is properly established on both sides the nasal bones are infrafractured and the perpendicular plate of the ethmoid straightened if necessary. The vestibular and septal incisions are closed, the nasal cavities packed to keep the mucosal flaps together and the nose immobilised in a POP splint. The nasal packs are generally removed after 48 hrs and nasal toilet done every alternate day. The POP nasal splint is discarded after 8-10 days.

Results

The postoperative period in all the cases has been quite uneventful and the results gratifying. No case has returned with symptoms of recurrent airway obstruction and objectively too, the airway has been well maintained. Cosmetically there have been some shortcomings. Some residual deviation or curvature of the dorsal line has been noticed in approximately 25% of our cases but only one patient (female) was unhappy with it. She was the only patient to undergo a repeat rhinoplasty (Fig. 4).

Complications

Residual deviation or curvature of the dorsal line is the commonest complication seen but this is certainly not the result of combining the two procedures. Supratip collapse and tip depression, however, are definitely more common with the combined procedure and must be guarded against at every stage. Two cases did have some degree of depression in the supratip region but this tendency was immediately corrected by inserting a strut of septal cartilage from the pieces removed by the ENT surgeon. There has been no absorption to date, i.e. 2 yrs. after surgery. The nasal tip of one patient dipped down at the end of the procedure and a cartilage strut had to be sutured to the columella to prop up the tip.

Discussion

There is no doubt in our minds that the one stage procedure is a very good operation and should be undertaken in all cases desiring a cosmetic rhinoplasty in addition to relief of symptoms of nasal obstruction. The reluctance with which this combined operation is undertaken by the majority of surgeons may be attributed to the fact that the procedure is much more difficult and takes twice as long, that one surgeon either 'Plastic' or 'E.N.T.' is not equally comfortable with both procedures and to the fact that two surgeons are notoriously difficult to get together. One added reason for the small number of SMR+Rhinoplasty done in our country is the ignorance on the part of patients and even doctors about cosmetic procedures and the embarrassment that it evokes. We do not, therefore, think it wrong to *inform* patients of the possibility

of cosmetic correction, in fact we now feel that it is even necessary to do so. All our patients made the choice entirely by themselves and none were sorry for having made it. Whether or not the combined procedure should be done by one or two surgeons depend entirely on the training and experience of the operator and is of secondary importance.

Conclusion

The combined procedure is recommended in all cases when a corrective rhinoplasty is contemplated in addition to SMR or septoplasty. The advantages of this far outweigh the disadvantages and the results both functional and cosmetic have been most gratifying to surgeon and patient, (Fig. 5).



Fig. 1. *a* Pre-operative Photograph.



Fig. 1. *b* Post-operative photograph.

A case of nasal obstruction associated with gross deformity of the nose.

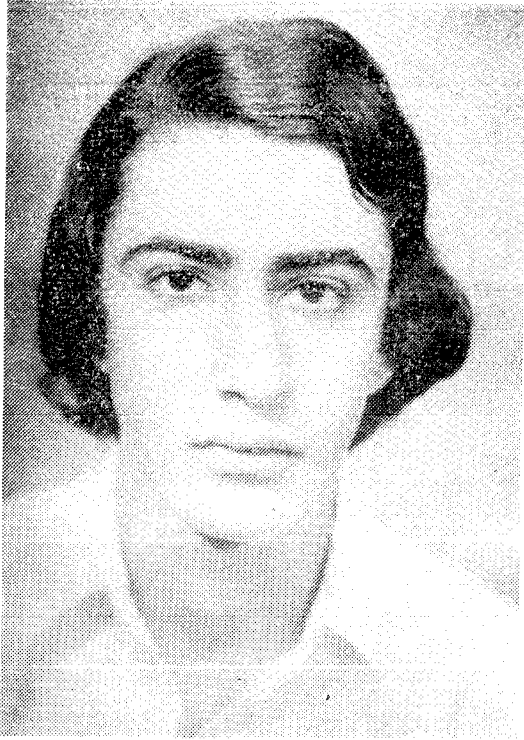
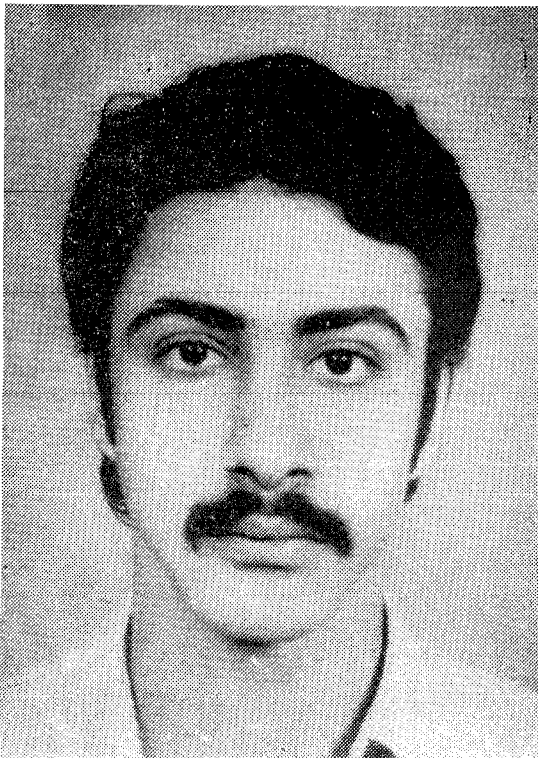
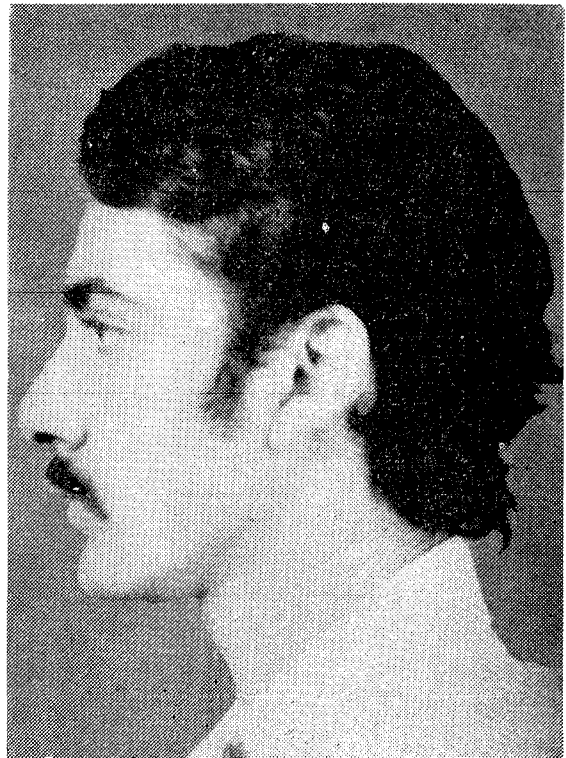
Fig. 2. *a*Fig. 2. *b*Fig. 2 *c*Fig. 2 *d*

Fig. 2. Nasal obstruction with deviation and a hump. Fig. 2. *a* & *b* Pre-operative photographs. *c* & *d* Post-operative photographs. Note some residual curvature of the dorsal line.

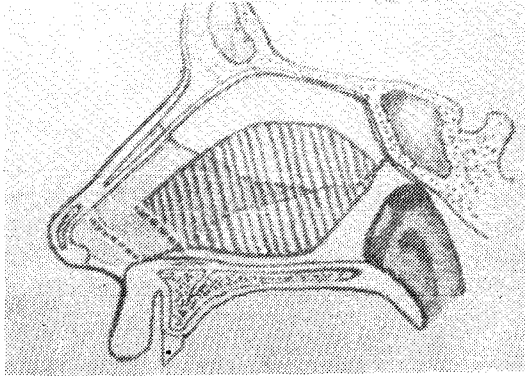


Fig. 3. The intracartilagenous incision through which the alar cartilages are reduced is more distal. The SMR or septoplasty is performed through a incision made atleast one centimetre behind it.



Fig. 4. *a* Pre-operative photograph



Fig. 4. *b* Post-operative photograph to show residual deviation of the nose.



Fig. 4. *c* After re-do rhinoplasty.

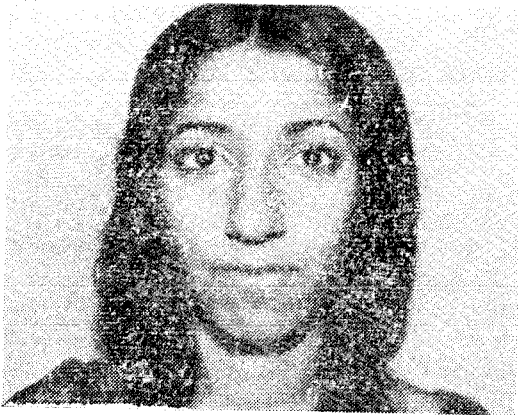


Fig. 5. a



Fig. 5. b

Fig. 5. a & b Pre-operative photographs.

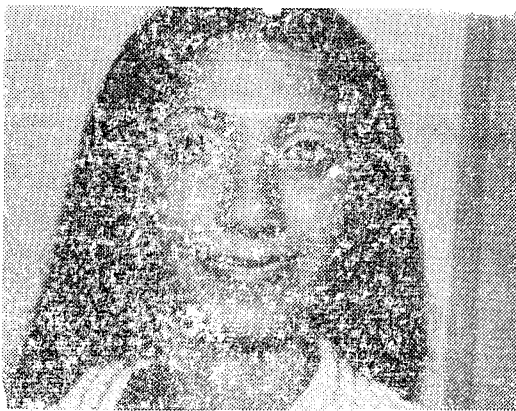


Fig. 5. c

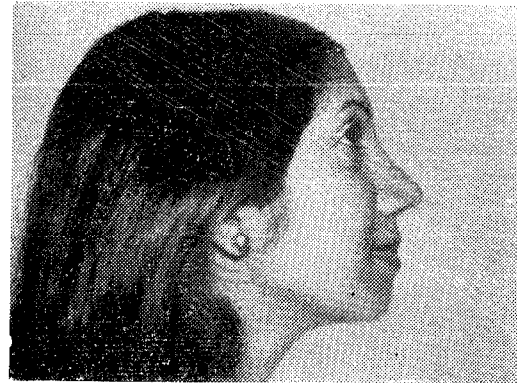


Fig. 5. d

Fig. 5. c & d Post-operative photographs.

Note the difference in the overall appearance of the patient attributed to the psychological boost the rhino plasty gave her. A simple S.M.R. would have corrected her airway problem but is that enough ?

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