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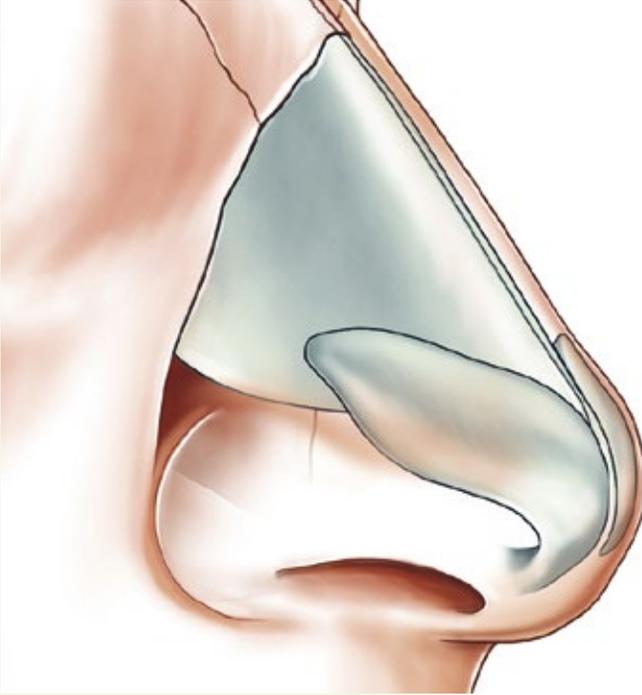


Figure 1a: if the lateral crus of the alar cartilages is oriented upwards, its orientation must be changed by bringing it closer to the margin of the nostril. Otherwise, once its cephalic margin has been resected, there would not be a sufficient strip of cartilage (measuring at least 2mm) left along the nostril to prevent the nasal ala from collapsing

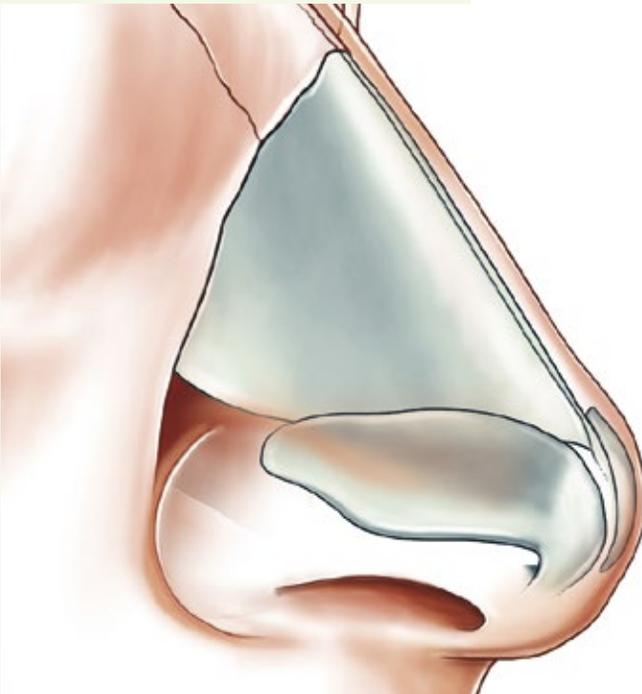


Figure 1b: normal orientation of the lateral crus fairly close to the edge of the nostril

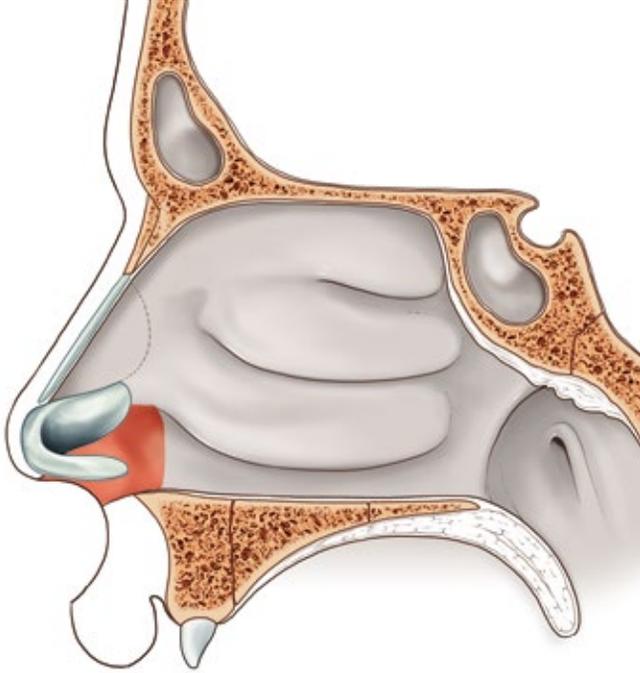


Figure 3a: Cottle area 1. Deviation in area 1 give moderate breathing problems. It usually causes a distortion of the nostrils

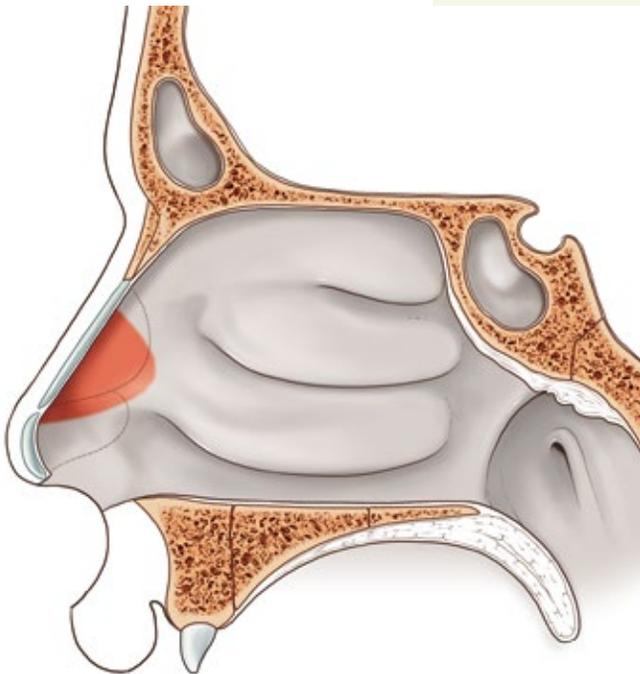


Figure 3b: Cottle area 2. Deviation in area 2 prevents the Mink Valve from functioning properly and cause breathing problems

injecting, as is done with any other injection, makes sure you are not inside a blood vessel (fig. 4).

When a deviation of the septum is to be corrected, the turbinate which is located in the widest nasal fossa is hypertrophic because it has to arrive to touch the septum in order to perform its function correctly (as explained earlier). It

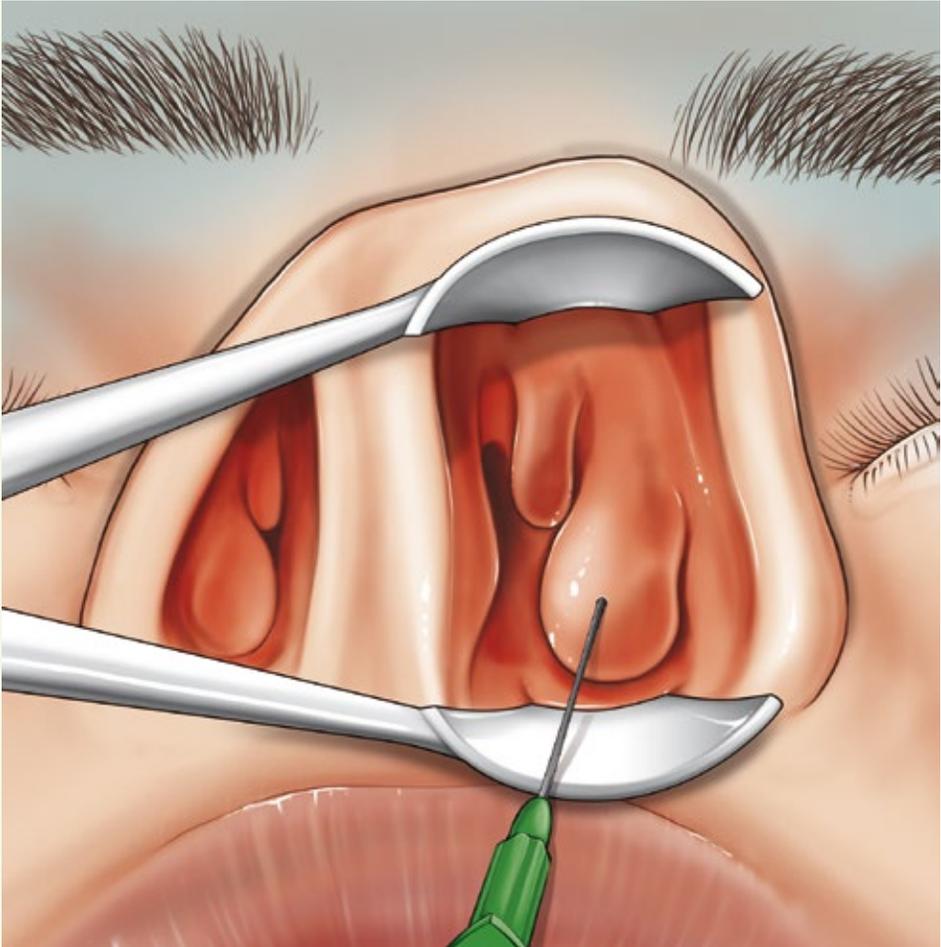


Figure 4: infiltration of triamcinolone in the head of the turbinate. This is effective when the allergic component is predominant, but dangerous because the substance injected can cause blindness via the bloodstream. If you decide to proceed, you must remain very superficial, aspirating before injecting, to be sure that you have not penetrated a blood vessel

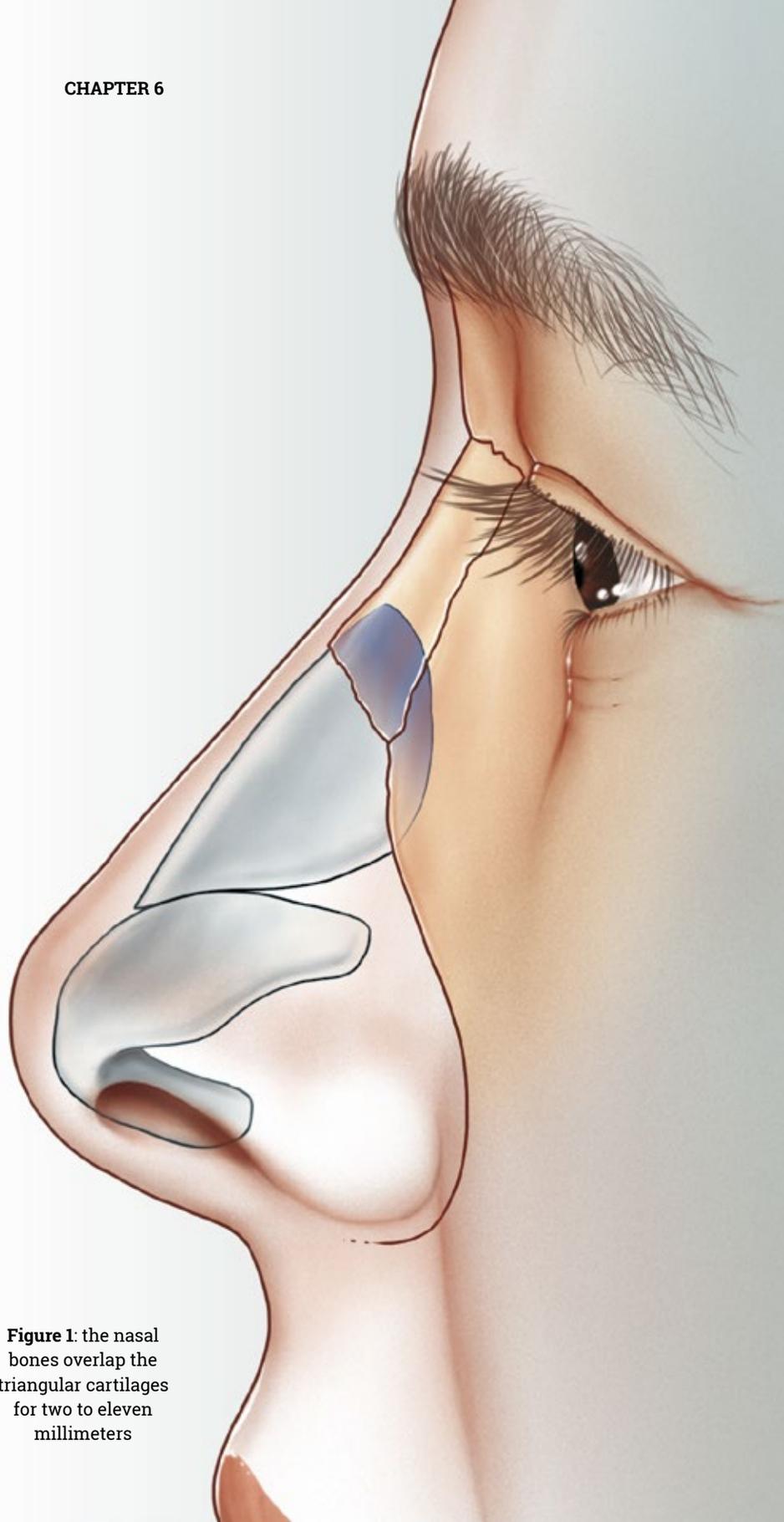


Figure 1: the nasal bones overlap the triangular cartilages for two to eleven millimeters

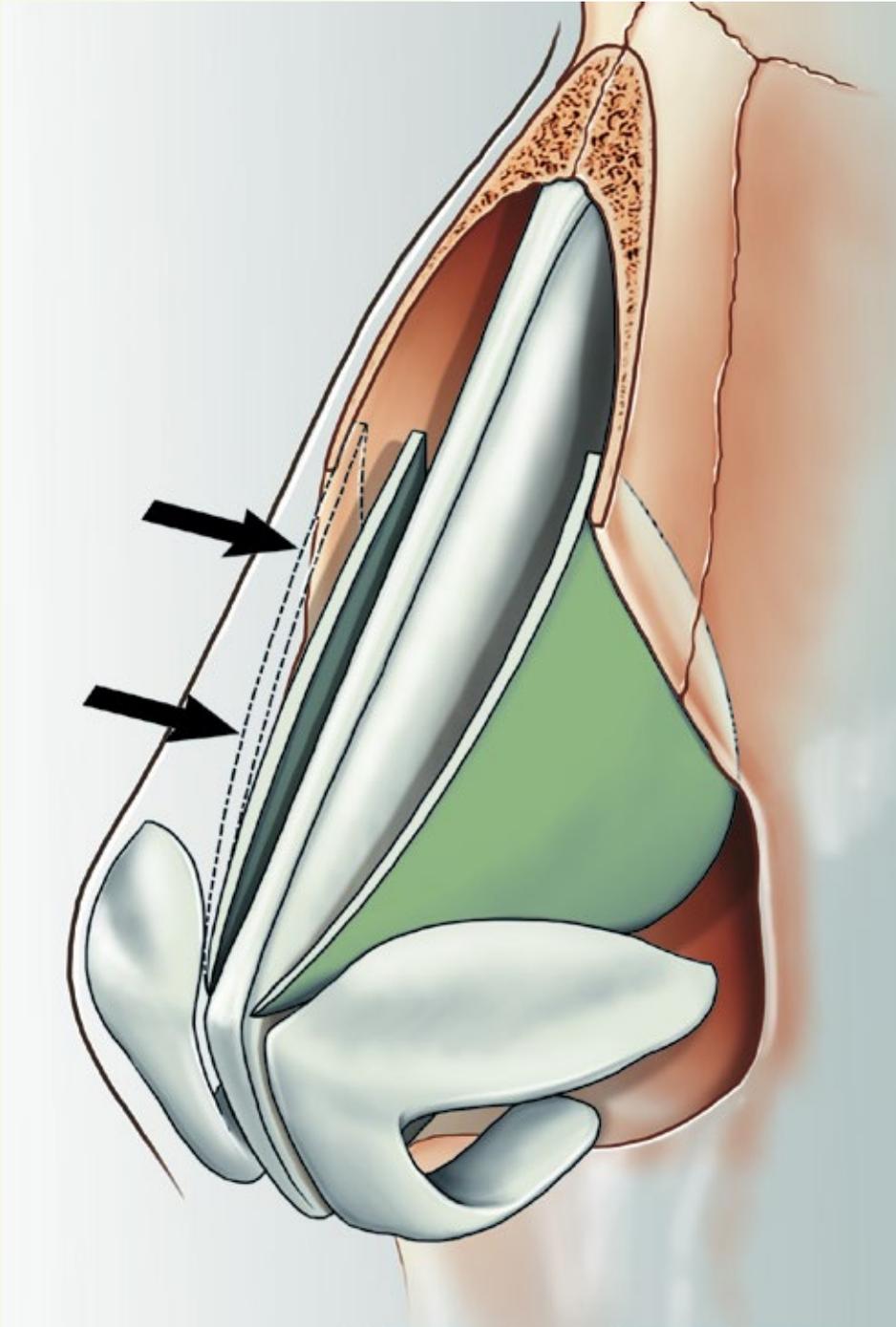


Figure 2: detachment of the triangular cartilage caused by incorrect maneuvers, usually by the use of rasps that hook it exerting a traction instead of consuming it

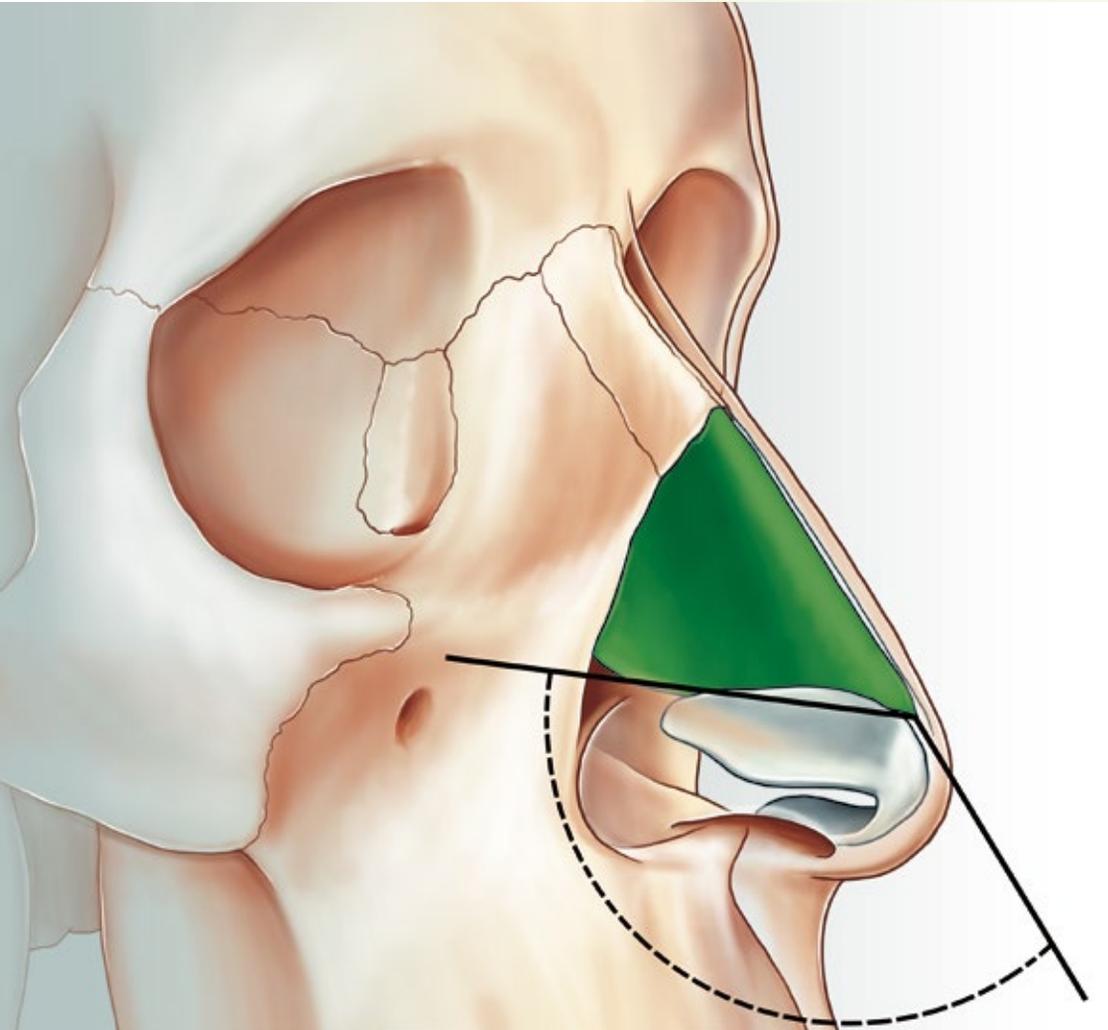


Figure 5: the angle that the free edge of the triangular cartilage makes with the septum should be approximately 120°

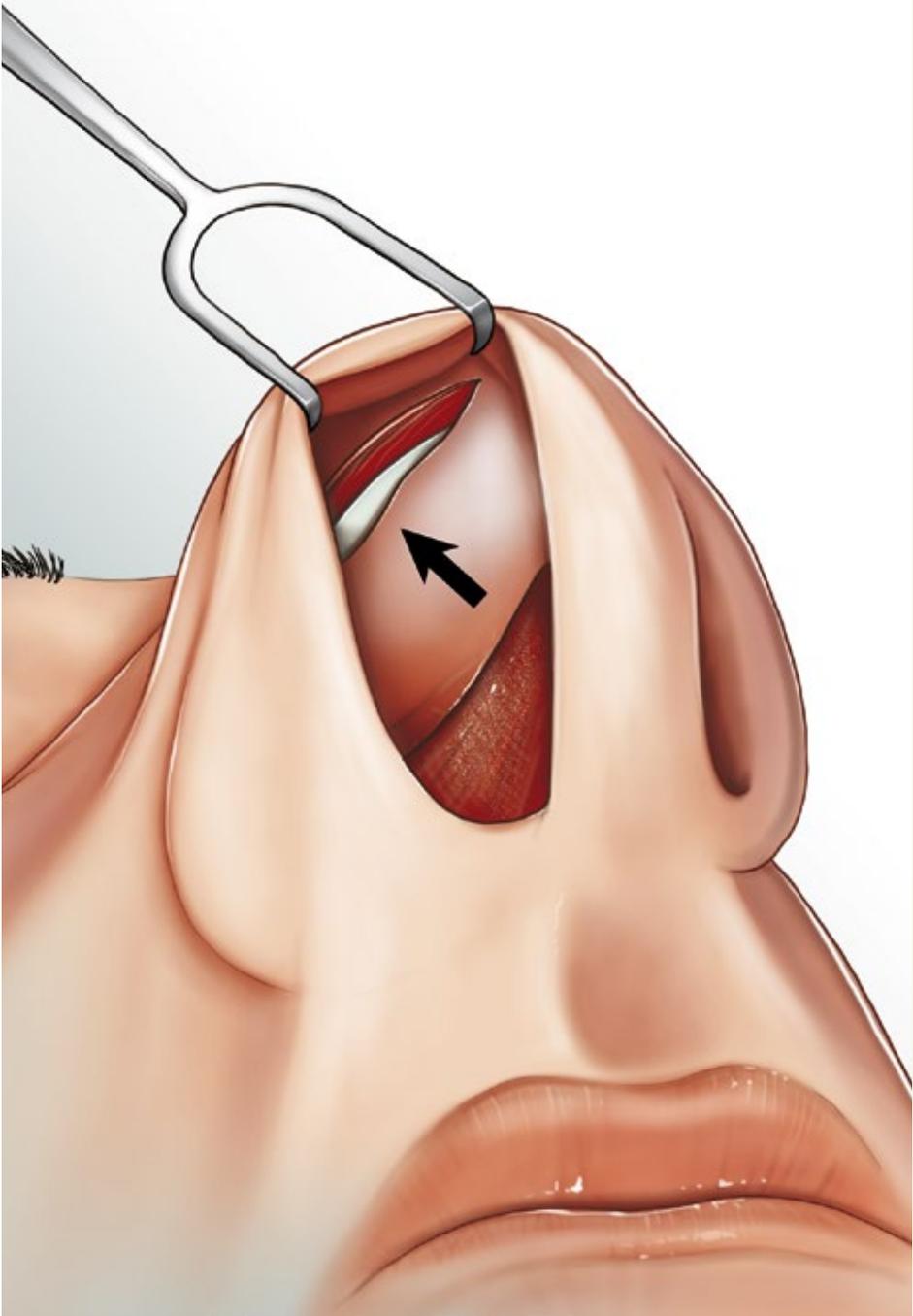


Figure 8b: removal of a lozenge of vestibular skin caudal to the lower margin of the lateral crus corresponding to how much you want to lower it



Figure 1: the lip remains elevated in the central part due to excessive projection of the tip of the nose

the lip and the anterior nasal spine are not interrupted, in order to allow the soft tissues to slide in relation to the underlying bone structure.

The procedure to perform this is: an incision is made along the labial frenulum, a Joseph's elevator is introduced, and the soft tissues are elevated from the anterior nasal spine and the lower part of the upper maxilla, just below the piriform aperture. The depressor septi nasi muscle, disengaged with this maneuver, will no longer exert its nasal tip depressing action when speaking or smiling. In profile lowering rhinoplasties the tension on the tip decreases as a result of the reduction of its projection, and after the above-described detachment has been performed, the soft tissues under the nose will eventually settle down. This will result in a better harmonization of the nose-upper lip ratio, and the lip will also appear visually fuller.

The labial frenulum is not normally modified but only used as a natural point to make the incision through which it is possible to introduce Joseph's elevator (figs. 2a, b). However, if deemed necessary it can also be lengthened and not only incised. In this case the lengthening can be done cutting it with scissors or with a simple Z-plastic.

The root of the nose (nasion is the name of the craniometric point that



Figure 2a: longitudinal incision of the labial frenulum



Figure 2b: septal depressor muscle detachment with Joseph's elevator



Figure 3: assessment of the root of the nose, pressing the soft tissues with a finger



Figure 4: the new line of the dorsum is drawn

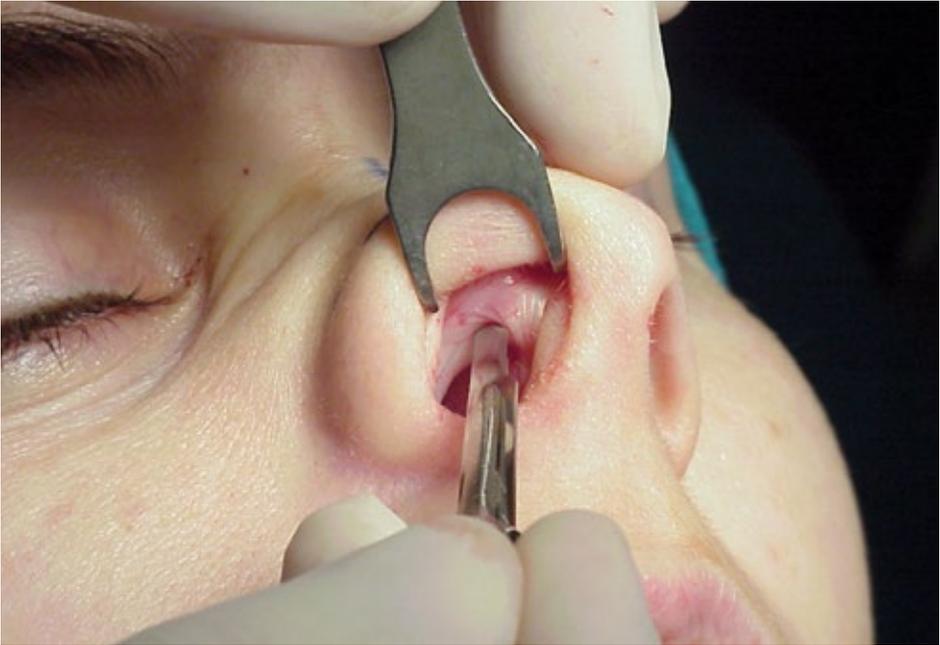


Figure 9: intercartilaginous incision made starting laterally just above the lower margin of the triangular cartilage



Figure 10: extension of the intercartilaginous incision to the front of the quadrangular septal cartilage

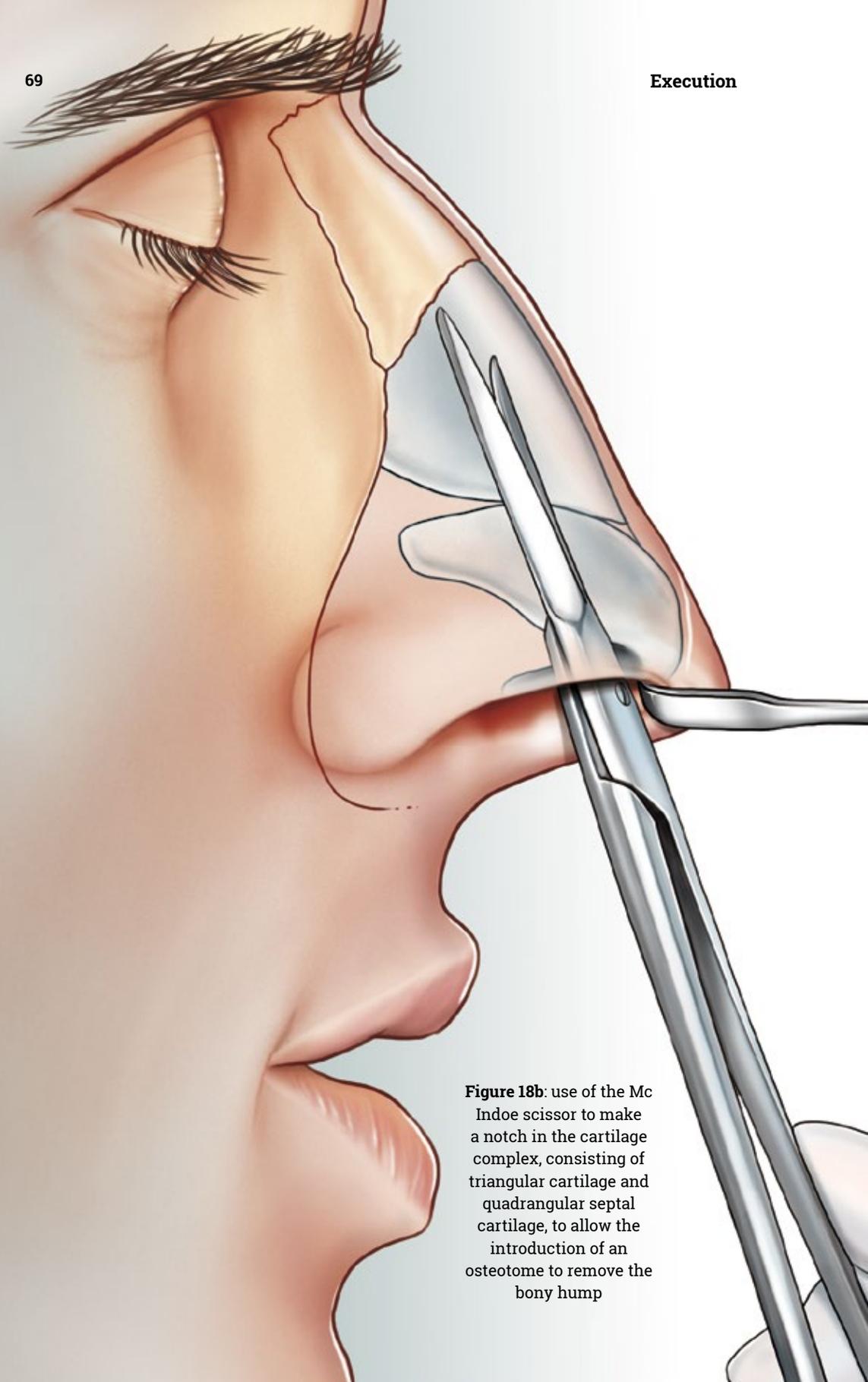


Figure 18b: use of the Mc Indoe scissor to make a notch in the cartilage complex, consisting of triangular cartilage and quadrangular septal cartilage, to allow the introduction of an osteotome to remove the bony hump



Figure 36b: drawing of the wedge-shaped excision involving the vestibule and part of the foot of the nostril. (Sheehan's technique) This drawing should be done slightly below the point where the internal curvature begins in order to preserve the roundness of the nostril. If it would be done exactly where the curvature begins, an angle would form and therefore the outline of the nostril would no longer be rounded



Figure 36c: to facilitate the removal, a stitch is placed in the center of the wedge of skin to be incised with a blade-11 scalpel and then removed



Figure 36d: reduction of the foot of the nostril achieved preserving the roundness of the nostril

The poorly projected tip

Diamond and hockey stick techniques are applicable in most cases. They are both slightly reductive or do not significantly change the projection. However, it can happen that the tip needs more projection instead.

When an increase in projection is required, an exposure of the alar cartilage through a marginal incision may be the first choice. The vestibular skin is incised caudally to the inferior margin of the alar cartilage. Laterally this incision follows the inferior margin of the lateral crus and medially follows the anterior margin of the medial crus along the columella. (figs. 37a, b).

A small point is located on the anterior margin of the alar cartilage, inferiorly to the junction between the lateral and medial crus, that I have called Deneb (see chapter 6) (fig. 38). This pin-point is a landmark which allows to operate exposing the cartilages of the tip from a single nostril without fear of not mastering asymmetries. In fact, joining the point (that



Figure 37a: marginal incision caudal to the lateral crus



Figure 37b: marginal incision along the columella