

# Alar Rim Deformities



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## KEYWORDS

• Alar rim • Nose • Deformity • Rhinoplasty

## KEY POINTS

- The alar rim plays an important role in nasal harmony.
- Alar rim flaws are common following the initial rhinoplasty.
- Classification of the deformities helps with diagnosis and successful surgical correction.
- Diagnosis of the deformity requires careful observation of the computerized or life-sized photographs.
- Techniques for treatment of these deformities can easily be learned with attention to detail.

## BACKGROUND

Alar rim harmony plays an important role in the nasal base balance. Inherited or iatrogenic deformities disturb the balance of this zone and engender a displeasing appearance. Retraction is the most common alar abnormality, and was the hallmark of rhinoplasties done in the 1960s and 1970s. Gunter and colleagues<sup>1</sup> classified alar rim abnormalities into 6 distinct subgroups based on two-dimensional observation. In 2001, Guyuron<sup>2</sup> modified the classification with a three-dimensional concept. This article describes deformities of the alar rim and the surgical techniques to correct them.

## CLASSIFICATION

### *Profile View*

By connecting a line from the apex of the nostril to the nadir of the nostril, if the alar rim is within 1.5 to 2 mm cephalic to this line, then the ala is in an optimal position. If this distance is more than 2 mm, the ala is retracted, and if the distance is shorter than 1.5 mm then patient has a hanging ala (**Fig. 1**).

### *Basilar View*

In a basilar view of the optimal nose, the 2 alar rims and nasal base create an equilateral

triangle. In this triangle, each ala is positioned in a straight line that constitutes a limb of the triangle. The 2 types of disharmony that might be observed in this view are concave and convex alar rims.

If the alar outline is medial to the leg of the triangle, then the ala has a concave shape. This condition is often a consequence of inappropriate interruption of the lower lateral cartilage, improper application of the tip graft that extends lateral to existing dome, a transdomal suture that is too tight, or excessive resection of the lower lateral cartilage.

If the ala is lateral to this triangle, then it is referred to as a convex ala. Two conditions may cause this abnormality: too much convexity to the lower lateral cartilage, or excessively thick ala (**Fig. 2**).

## SURGICAL CORRECTION OF THE DEFORMITIES

The hanging ala can be easily corrected by removing an elliptical alar lining along with a proportionate amount of subcutaneous tissue and leaving the skin intact (**Fig. 3**). This procedure is extremely simple. However, the hanging ala is a rare condition.

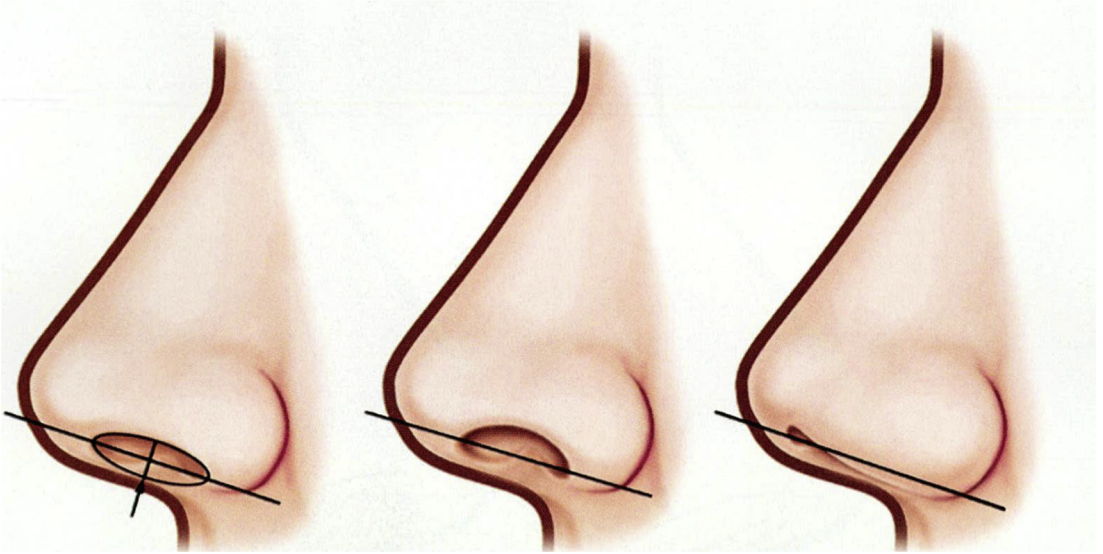
The most common abnormality of the ala in the lateral view is a notched or retracted ala. A variety

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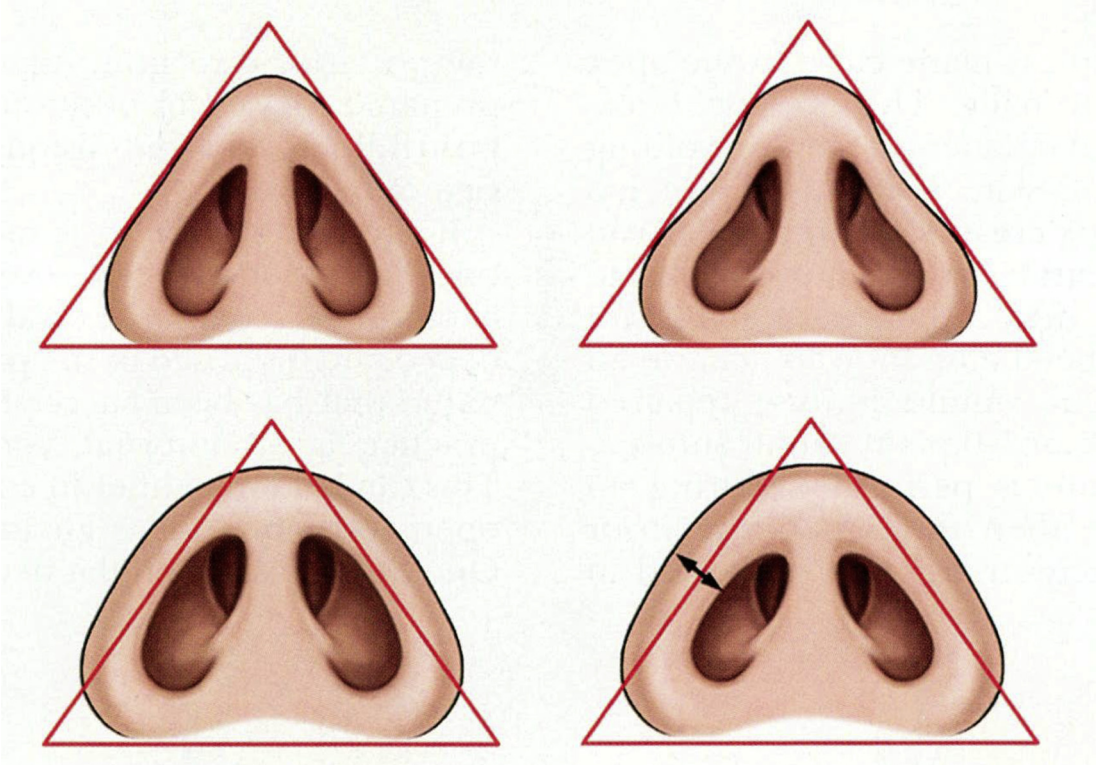
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**Fig. 1.** (Left) A line connecting the apex of the nostril to its nadir divides the nostril into 2 equal halves. (Center) A retracted or notched ala exists when the distance from this line to the alar rim is greater than 1.5 to 2 mm. (Right) A hanging columella occurs when the distance is less than 1.5 to 2 mm. (Adapted from Gunter JP, Rohrich RJ, Friedman RM. Classification and correction of the alar-columellar discrepancies in rhinoplasty. *Plast Reconstr Surg* 1996;97:643; and Guyuron B. Alar rim deformities. *Plast Reconstr Surg* 2001;107(3):856–63, with permission.)



**Fig. 2.** In a pleasing basilar view, the alar rims are located within an equilateral triangle (above, left). Artistic renderings of a concave ala (above, right), a convex ala caused by excessively convex lower lateral cartilage (below, left), and a convex ala caused by excessively thick ala (below, right). (Adapted from Guyuron B. Alar rim deformities. *Plast Reconstr Surg* 2001;107(3):856–63; with permission.)

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