

Rhinoplasty in the Middle Eastern Nose



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KEYWORDS

• Rhinoplasty • Middle Eastern nose • Thick skin • Dorsal hump

KEY POINTS

- In Middle Eastern noses, do not try to over-reduce nasal dorsum to make the nose smaller.
- Try to teach the behavior of thick skin to the patients.
- Support the tip structures.
- Try to keep the ethnic characteristics.

 A video of revision rhinoplasty on a Middle Eastern nose accompanies this article at <http://www.facialplastic.theclinics.com/>

INTRODUCTION

The Middle East is a region that roughly encompasses a majority of Western Asia and Egypt.¹ Twenty-eight ethnic groups live in 18 countries with Arabs, Turks, and Persians taking the lead. This is the area where world civilization started, and also this is the region for never-ending population changes throughout the history. Nevertheless, having the chance to visit, lecture, and operate in many of these countries, the author can say that there are many similarities in nose and face features.

In the literature written on the Middle Eastern nose, thick skin, dorsal hump, overprojected radix, wide upper two-thirds, nasal deviation, poorly defined and underprojected tip, weak lower lateral cartilages, acute nasolabial angle, and nostril tip asymmetries have all been reported to be seen with varying ratios.²⁻⁶ In a photogrammetric study done in a Turkish population, crooked nose, obtuse nasofacial angle, and acute nasolabial angle were found to be the major problems for patients seeking rhinoplasty.⁷ Similar results seem to be valid for Arabic noses as well.⁸

Traditional Turkish noses are usually big, with humps of varying degrees. The biggest humps are found in the Black Sea region of Turkey, where the longest nose on a living person recorded in the

Guinness Book of World Records comes from.⁹ In all the Middle Eastern countries, dorsal hump is almost invariably the primary reason for seeking rhinoplasty.

According to the author, the skin thickness of the nose increases in southern and eastern parts of the Middle East; this increase has also been reported in the literature.^{3,10} Skin color also gets darker in a similar fashion. That is why triamcinolone injections are more popular in these countries. One of the major problems caused by skin thickness and darker skin is the increased visibility of external rhinoplasty incisions.^{11,12}

TREATMENT GOALS AND PLANNED OUTCOMES

The challenge is that the use of a standard approach to the patients coming from different ethnic origins seems impossible. On the other hand, many of the problems for rhinoplasty patients in Middle Eastern countries show similarities, meaning a well-planned operative plan can be valid for most patients. The treatment goals for most patients can be summarized as follows:

1. Flat or slightly curved dorsal profile
2. Adequate tip projection and rotation

Disclosure: No disclosures.

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Facial Plast Surg Clin N Am 22 (2014) 349–355

<http://dx.doi.org/10.1016/j.fsc.2014.04.009>

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3. Better tip definition
4. Narrower and smaller nose
5. Better tip support
6. Middle vault reconstruction
7. Straight nasal septum

PREOPERATIVE PLANNING AND PREPARATION

One of the most important stages of rhinoplasty is to understand the goals of the patient, which necessitates a careful history taking. In the Middle East, the goals of patients may differ from country to country and from ethnic group to ethnic group. In some countries, the women are very eager to have very small noses and look more like a Caucasian. In the author's patients, the tendency is to have a nose that looks natural and functional.

When a patient is accepted to be operated by the author, 11 pictures are taken: frontal, laterals, obliques, basal, frontal smiling, lateral smiling, and 3 views by putting a ruler on 1 side of the head (frontal, lateral, basal). These pictures are transferred into Rhinobase, a computer program designed specifically for rhinoplasty patients, for aesthetic and photometric analysis.¹³ After a thorough facial analysis in Rhinobase, the frontal, lateral and basal views (the ones including ruler) are transferred into Photoshop (Adobe Photoshop CS5 Version 12 [Adobe Systems Incorporated, San Jose, CA, USA]), where image processing is done with the patient in the consultation room. This stage is of utmost importance, because the patients express their requests; then the surgeon can simulate the desired shape and tell them how to reach these goals surgically and also the limitations in each individual case. Starting from the radix, the author usually tells his patients that he is usually reluctant to lower the radix while lowering the nasal dorsum, because it is too difficult to obtain a satisfactory result. While planning the dorsum, the author usually gives the female patients 2 options: a flat dorsum or a little curved one. Within the last decade, almost none of the patients the author saw have been seeking for overly done nasal dorsums. In the author's experience, it is not the same in all the countries in the Middle East. For example, in Iran many surgeons are still asked to make the noses very small with an overly reduced dorsum.

PROCEDURAL APPROACH

The author prefers to operate all his patients under general anesthesia. In 80% of the cases, an external approach is used. After the local anesthetic is applied, an inverted-V incision and

marginal incisions are performed. The columellar flap is elevated by using sharp curved scissors, and the incision edges are cut perpendicular to the wound edges. Then the caudal end of the medial crura and the lateral crura are dissected. The middle third is dissected on a supraperichondrial plane and upper third in a subperiosteal plane. In recent years, the author generally has cut the perichondrium of the middle third in the midline and dissected it to both sides to skeletonize the medial aspect of the upper lateral cartilages. This layer can be of help to cover the middle vault just before closure. Usually the soft tissue in the interdomal, intercrural area and over the nasal spine is resected in order to minimize postoperative swelling and facilitate graft insertion. The depressor septi nasi is also usually cut at this stage, which can pull the footplates of the medial crura to destabilize the nasal tip. The caudal end of the nasal septum is exposed by using sharp dissection with a curved scissors. Half of the caudal segment is exposed, and then small tunnels under the cartilaginous dorsum are opened by using a Freer (Medtronic ENT, Jacksonville, FL, USA) elevator to facilitate the detachment of the upper lateral cartilages from the dorsal segment of the nasal septum. If there is a septal deviation or if septal cartilage is needed for grafts, the nasal septum is exposed bilaterally by keeping the 3 to 5 mm of mucoperichondrium attached to the cartilage at the level of the lower half of the dorsal segment. An L-strut of 12 to 15 mm is kept in place while harvesting the rest of the cartilaginous septum. If the bony septum is deviated, or long splinting spreader grafts are needed, then the bony septum is also harvested without breaking its attachment with the cartilage. In order to correct the difficult septal deviations, the rules of segmental reconstruction are applied.¹⁴ The next step is to cut the upper lateral cartilage (ULCs) from the nasal septum sharply by scissors or scalpel. In accordance with the preoperative plan, the amount of cartilaginous septum is resected by scalpel, and the bony part is removed by using Rubin osteotome. ULCs are turned in as spreader flaps when the amount of resection of the cartilaginous septum is more than 3 mm. Otherwise, spreader grafts are used to restore the middle vault or to correct deviations of the dorsum. The bony part is rasped to lower the upper third after the middle vault is reconstructed. At this stage, medial fading osteotomies are performed by 3 mm guided straight osteotome, followed by gentle rasping and irrigation.

Tip bulbosity and droopiness are 2 major problems encountered in the Middle Eastern nose. One of the author's favorite techniques to solve

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