Rhinoplasty for South East Asian Nose

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KEYWORDS

• South East Asian • Rhinoplasty • Surgical approach • Sail excision • Vestibular groove • Hanging ala

KEY POINTS

- South East Asian noses are usually small with voluminous thick skin, low dorsum, wide and hanging ala, bulbous tip, and retracted premaxilla.
- South East Asian noses possess characteristics that are different from other ethnic noses; the chronology of surgery is also different.
- In general, the following alterations are needed: dorsal augmentation, counterrotation and projection of the tip, and lastly correction of hanging ala and alar flare/base.

INTRODUCTION

South East Asia comprises a population mainly of Malay origin. The noses are usually small with voluminous thick skin, low dorsum, wide and hanging ala, bulbous tip, and retracted premaxilla (**Fig. 1**). The surgical approach of rhinoplasty for these type of noses is different from the usual. In general, the following are needed: dorsal augmentation, counterrotation and projection of the tip, and lastly correction of hanging ala and alar flare/base.

Septal and conchal cartilage are commonly used; however, costal cartilage may be used in secondary cases where septum is depleted. The scope of surgery (not necessarily in order) requires the following: (1) a strong structural framework using the central septal cartilage as septal extension graft (SEG), (2) contoured framework using conchal cartilage (eg, tip grafts), and (3) soft tissue contouring of the tip and ala.

Because the South East Asian nose possess characteristics that are different from other ethnic noses, the chronology of surgery is also different. Often times, conchal cartilage are harvested initially for contour framework grafts. Then the nose is analyzed whether a hanging ala is present by manually derotating and projecting the tip. If there is hanging ala, it is corrected at this moment because of the need of maneuverability of the alar for marking, incision, excision, and suture closure. It is corrected via excision of a triangular tissue shaped like a sail inside the nostril. After alar rim is lifted, formal rhinoplasty commenced via open approach. The septum is dissected bilaterally and the central cartilage harvested and used as support graft mainly as SEG. Conchal grafts are used as contour grafts. Osteotomy, if indicated, is done at this point. Because volume is needed in dorsal augmentation, synthetic material, such as silicone and expanded polytetrafluoroethylene (e-PTFE; Gore Tex, W.L. Gore and Associates, Newark DE), is often used. The skin and soft tissue envelope (SSTE) is then draped and analyzed whether any additional grafts are needed. The columellar incision is closed at this time and attention is shifted again to the tip. If the tip is not showing its desired projection because of the thick skin, defatting is done. Once the effect of the new dorsum and tip are achieved, the bilateral marginal incision is closed. Attention is now focused in the ala. If the ala is still flared and wide, alarplasty is performed.

Disclosure Statement: The author has nothing to disclose.
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Facial Plast Surg Clin N Am ■ (2018) ■–■
https://doi.org/10.1016/j.fsc.2018.03.012

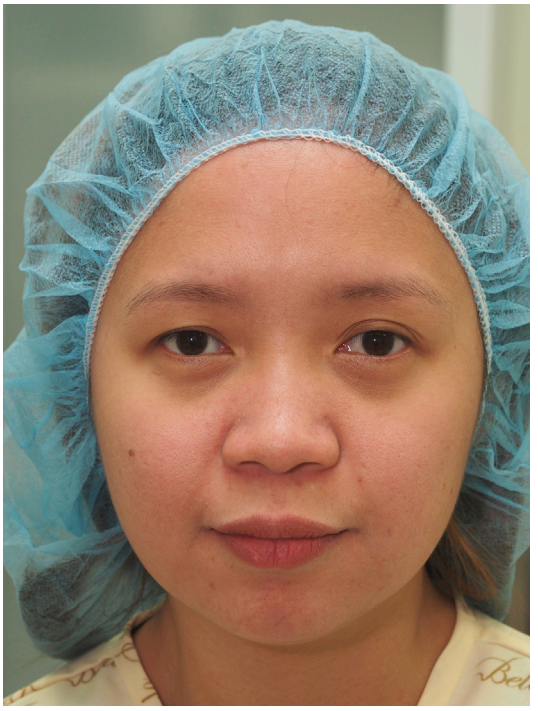

Fig. 1. A typical South East Asian nose.

SURGICAL TECHNIQUES IN DETAIL

Harvest of Conchal Cartilage: Mainly for Contour Graft and Backup Graft for Septal Extension Graft Support

Because of the small nasal structure of South East Asian nose, the septal cartilage harvested is often just enough for use as support graft so almost always the conchal cartilage is harvested for use as contour graft (eg, tip grafts).[1] Conchal cartilage is sometimes used as support for a weak or small SEG.[2]

The conchal cartilage is harvested as one piece to include cymba and cavum concha. Both sides should include its perichondrium to maintain its strength. Helix and antihelix should be preserved at all times. Approach to the harvest is done anteriorly at the inferocaudal portion of the cavum conchal bowl. If bigger cartilage material is needed, approach should be posterior for more exposure. It is best to retain 5 mm of helical crux and to use bolster dressing to preserve the conchal bow and avoid collapse of the ear.[3] Keloid can occur in posterior incision; therefore, if the patient has a keloid scar elsewhere, avoid posterior incision.

Once cartilage is harvested, it is soaked in normal saline solution. Closure of incision is done using nylon 5-0 simple interrupted. A bolster dressing is applied over the conchal bowl to prevent hematoma formation.

Sail Excision for Correction of Hanging Ala (Part of Soft Tissue Contouring): For That Extra Aesthetic Advantage in Ala-Columellar Relationship

Achieving a good ala to columellar relationship brings harmony to the tip and to the whole nose. On front view the ala-columella should simulate a gull's wing in flight wherein the alar rim is superiorly directed (**Fig. 2**). On lateral view the highest arc of

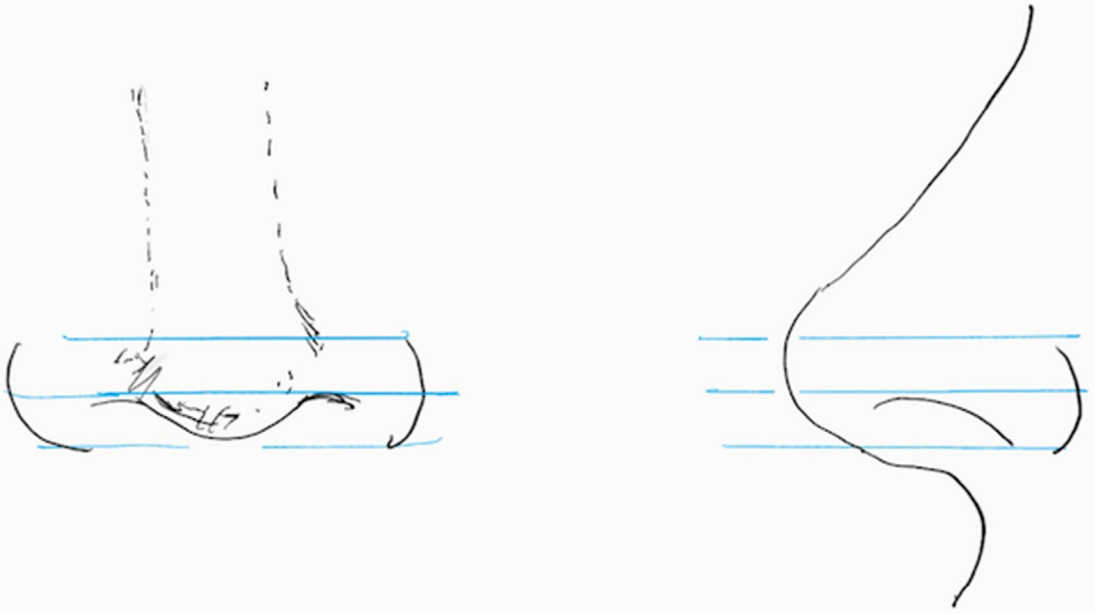

Fig. 2. The highest point in the alar rim transects equally the tip and subtip. (*From* Gunter JP, Rohrich RJ, Friedman RM. Classification and correction of alar-columellar discrepancies in rhinoplasty. Plast Reconstr Surg 1996;97:643–8; with permission.)