

ISAP S[®] NEWS

OFFICIAL NEWS OF THE INTERNATIONAL
SOCIETY OF AESTHETIC PLASTIC SURGERY

4

Volume 14 | Number 4



INSIDE ■

Global Perspectives:
Rhinoplasty

Spotlight on
National Secretaries

History of Rhinoplasty

New Directions
in Education

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2024
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NOTICE OF NEW ADDRESS

ISAPS has moved administration to virtual offices.

Please make a note of our new address:

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The telephone number remains the same:

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MESSAGE FROM the Editor

Dear Colleagues,

I hope that this issue finds you, your families, and your staff in good health.

This issue's focus topic is rhinoplasty and we received a tremendous variety of articles, each of which discusses a different aspect of this technically challenging procedure. It is notable that all authors emphasize the need to think in three dimensions as well as the critical importance of respecting the balance of the nose. Both surgical and non-surgical approaches are presented, and I highly recommend review of this diverse series of articles.

Riccardo Mazzola has once again provided us with the historical perspective of the series topic, which includes a fascinating treatise on the work of Jacques Joseph, whose vast body of work has contributed enormously to both the knowledge of and instrumentation of aesthetic and reconstructive rhinoplasty surgery.

As you may know, our National Secretaries work very hard to bridge the communication between the Board of Directors



and our members. We have highlighted three of them in this issue: Luiz S. Toledo (NS-UAE), Montserrat Fontbona (NS-Chile), and Manoj Khanna (NS-India). Their backgrounds and interests are as varied as they are impressive, and we thank them for sharing their stories with us.

Finally, as many of you already know, our Executive Director Catherine Foss is finishing her time with ISAPS at the end of this year. She has written us a heartfelt letter of goodbye which details the significant role ISAPS has played in her life. Please be sure to reach out to her with your best wishes at catherine@conmx.net.

I wish you a safe and happy holiday season, with the promise of a brighter 2021. Thank you for all you do for ISAPS.

A handwritten signature in black ink that reads "Nina S. Naidu MD FACS". The signature is fluid and cursive.

Nina S. Naidu, MD, FACS, Editor-in-Chief (United States)



MESSAGE FROM the ISAPS President

Dear Friends and Colleagues,

2020 continues to be a difficult year due to the impact of COVID-19 on many countries worldwide. A lot has changed in the past few weeks, with new regulations in some places and lockdowns in others. Many of us are once again facing practice closures, restrictions on who we can visit, and travel bans. Now more than ever, it is important to remember that we are not alone and to connect with others where we can. I would like to remind you all that as ISAPS members, no matter where in the world you may be, we are all united in our ISAPS family.

We had a very successful Virtual Olympiad and General Assembly on September 5th with an attendance of over 2,000 plastic surgeons. I would like to thank Past President Dr. Dirk Richter and the organizing team for the outstanding meeting. Immediately after the General Assembly, the newly-elected Board of Directors got to work and set up ISAPS Committees. During the last three months, I have had several meetings with the Committee Chairs to plan our activities for the next two years and our strategy during the Coronavirus era. The Committee Chairs are now having meetings with Committee members to make concrete plans and discuss possible strategies.

As ISAPS President, one of my first initiatives was listening to our members to understand their expectations from ISAPS in this extraordinary time. Along with some ISAPS Board members, I met with the leaders of several Asian and Middle Eastern societies. During these meetings, we had a friendly discussion regarding how we can improve collaboration and how we can increase ISAPS activities and membership in these countries. It was a very productive meeting and we

left with some great ideas for future activities and how to improve communication.

In addition, I organized a Strategic Planning Meeting with ISAPS Global Alliance leaders where I heard from our partner societies on topics like patient safety, global accreditation and resident teaching, and global standards and guidelines. Together with Drs. Lina Triana, Michel Rouif and Bertha Torres, I also met with our National Secretaries. In our meeting, we talked about communication between plastic surgeons and patients, strategies for membership growth, and how to continue improving the quality of ISAPS education. Our National Secretary army has an essential role in connecting ISAPS' management with its members. I plan to meet with the National Secretaries every three months to listen to their opinions and requests.

I am pleased to share with you that despite the current situation, ISAPS is continuing to bring the best in aesthetic education to our members. COVID-19 has caused significant changes to traditional teaching methods. As a leader in aesthetic education, ISAPS will continue to provide educational events for plastic surgeons in this new era using different teaching modalities. Our Education Council Co-Chairs, Dr. Ozan Sozer (USA) and Dr. Francisco Bravo (Spain), have been working with the Education Council on a comprehensive educational program to teach the most recent innovative techniques in aesthetic plastic surgery. Our Master Class webinar series, featuring world-renowned experts discussing different topics in each session, will continue next year to support aesthetic surgeons with ongoing education no matter the situation.

For the first half of 2021, our Education Council has already planned several exciting educational events. In February, we will hold a “Voice of ISAPS” meeting, where members will be able to present in front of their peers and will have the opportunity to see other members’ work and discover new techniques and ideas.



I am pleased to announce a non-stop, two-day virtual ISAPS World Meeting on March 27-28, which will feature sessions for viewers around the world. Please mark your calendars – you won’t want to miss this virtual event featuring expert speakers, a top educational program, and a special live program no matter where you are located. Stay tuned for more details!

Finally, we have two full-day events featuring top experts planned for you in April and May. In April, there will be a virtual Practice Management Meeting in April chaired by Dr. Renato Saltz, and in May we will host a virtual “ISAPS Regenerative Surgery Meeting.” More details will be announced soon, so save the dates.

As ISAPS President, I am incredibly proud that ISAPS membership is now over 4,700 members strong. Let’s

keep that number growing! Your membership is extremely important to ISAPS and we are honored to have you as a member. We value your commitment and dedication to ISAPS. From now until the end of the year, you can renew your ISAPS membership to stay part of our global network of experts in aesthetic surgery. As an ISAPS member, you get access to a whole host of benefits made available especially to you, even during these difficult times. Some of these benefits are more important than ever, now that courses and events have been limited around the world.

I know that times are tough right now, so I am happy to announce that we have also established discounted renewal options for Active members. When renewing this year, you can opt to renew your membership for 2 or 3 years at once and save on membership dues. Visit www.isapsmembership.org/pay-dues to renew today or www.isapsmembership.org/apply-for-membership to become a new member. Only with your support can we keep creating new and exclusive benefits for our members.

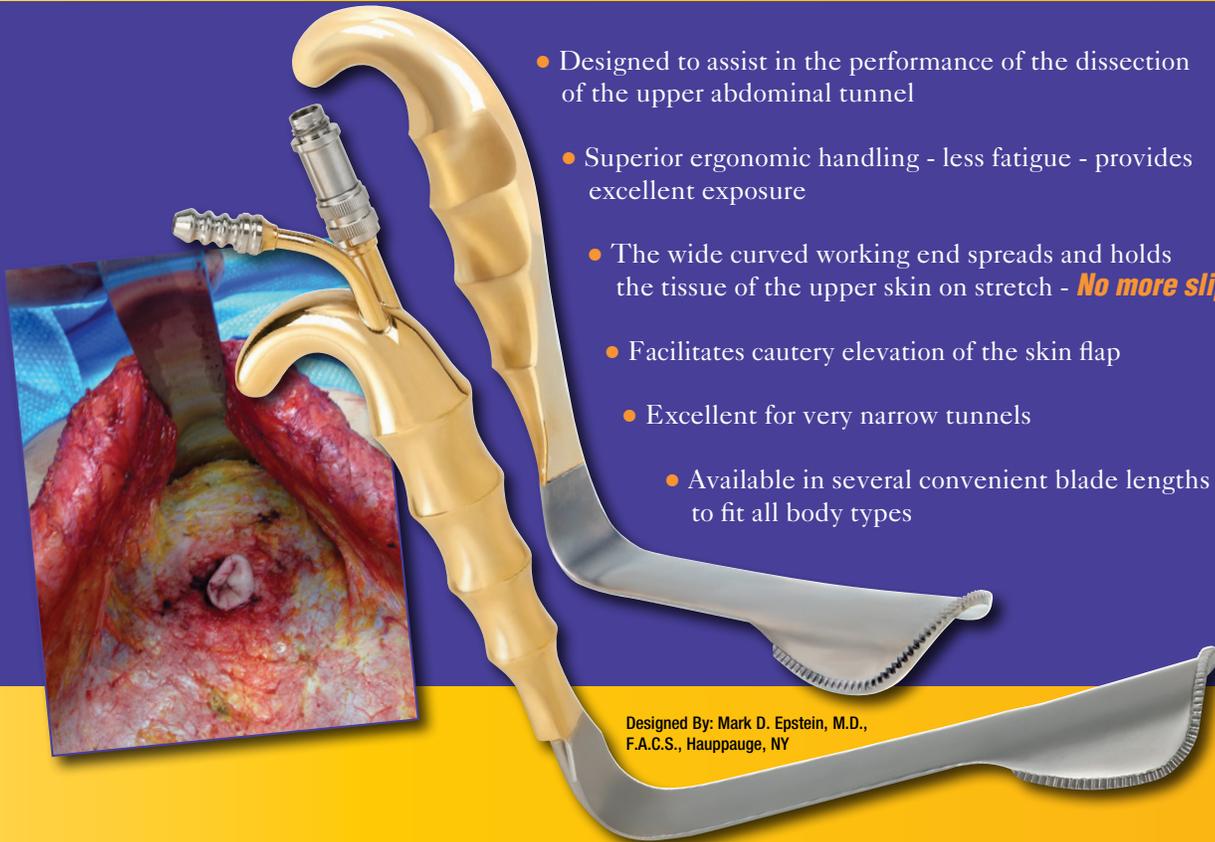
Thank you for being part of the ISAPS family. Stay healthy and remember – ISAPS unites us. Wherever you go, you are part of the ISAPS family. I hope you continue to stay with us as one of our esteemed members.

A handwritten signature in blue ink that reads "Nazim Cerkes".

Nazim Cerkes, MD, PhD
ISAPS President, 2020-2022

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MESSAGE FROM THE EDUCATION COUNCIL CHAIR



OZAN SOZER - UNITED STATES
Chairman, ISAPS Education Council

Dear ISAPS Members,

2020 has been a challenging year for all of us. I remember my last live meetings in February when I went to India for the AESURG meeting and then to Salt Lake City for the American Brazilian Aesthetic Meeting. For some reason, I feel as though they happened years ago. In reality, it has only been seven months. Feeling like this has really put into perspective how important live educational sessions have been in our lives.

Yet, for the sake of global safety, the world stopped live meetings, and now the virtual platform has become the new standard. In our efforts to continue providing the best aesthetic education worldwide, since the end of March, ISAPS has been organizing Master Class webinars for our members that are available on demand on our website. However, as we all know, the abundance of webinars available per week creates an inflation of information.

In my opinion, every crisis creates an opportunity. Now, we have the chance to organize events that we could not do at regular times. Currently, the ISAPS Education Council is exploring these possibilities to see what we could do differently for our members. Of course, we will continue with our series of webinars. In addition, our President, Dr. Nazim Cerkes, organized a hair transplant course in May and a rhinoplasty course in December with both courses including live surgeries. Along with this, in February, we will organize a unique event called Voice of ISAPS where residents and members can present their work or ideas in an abstract format. We will proceed

to choose the best presentations in each category to place these lectures in our larger meetings.

Another unique event we will organize is ISAPS WORLD that will take place on March 27th and 28th. This is an event where the whole world will come together, and the sun will not set on ISAPS for those 48 hours. Every region has their own organizing committee, and they will include a program with their best speakers. As the sun first rises in Australia, this program will start there before moving to East Asia, India, the Middle East, North Africa, Europe, and the Americas, before returning to Australia and repeating this process once again, making two rotations around the world. This meeting will be organized on a unique, interactive platform, and there will be translations to Mandarin, Russian, Spanish, Portuguese, and English.

Then in April, Dr. Renato Saltz will be putting together a virtual ISAPS business school, which will be followed up by an ISAPS Regenerative Medicine Meeting in May.

If all goes well, by the end of these six months, I hope we will at least start some hybrid events and be able to come together in Vienna for our biennial meeting that was postponed this year.

I hope 2021 will be a better year for all of us. The ISAPS Education Council will continue to stay busy to bring our members the best aesthetic education in the world.

Stay safe, stay healthy.

PATIENT SAFETY

RHINOPLASTY



JAMES FERNAU - UNITED STATES
ISAPS Patient Safety Committee

Patient safety in rhinoplasty begins with the history and physical examination. A careful history of bleeding problems is of paramount importance. Common drugs should be screened such as aspirin, ibuprofen, warfarin and many others. Also, there is an increasing number of foods, drinks and supplements which are now on the market and cause bleeding. Table 1 lists some of these agents.

Table 1

- Turmeric
- Cayenne pepper
- Vitamin E
- Ginseng
- Garlic
- Cassia cinnamon
- Ginkgo biloba
- Grapeseed extract
- Dong quai
- Feverfew
- Bromelain
- Takeaway
- Alcohol

Some women bleed quite heavily during their menses and it may be necessary to schedule surgery around heavy menstrual periods.

Document preoperative anosmia and or taste disturbances especially during the COVID-19 pandemic.

Discussions of preoperative PCR molecular testing should be discussed with the patient as most hospitals and/or surgical centers are currently requiring this test prior to aerosol generating procedures.¹

During the physical exam, look closely for previous scars around the nose such as a bull horn lip lift. Any scars around the nose and face that could impair blood supply to an open rhinoplasty should be thoughtfully recorded. Note any evidence of previous septoplasty surgery, nasal polyps and sinus disease. Nasal endoscopy is quite helpful for a complete evaluation. Preoperative imaging may be necessary to rule out sinus disease which can be addressed either before the rhinoplasty or during the rhinoplasty as one of the first steps performed by the otolaryngologist. Examine the ears and ribs to make sure the cartilage is intact for possible grafting.

Prior to the procedure it is helpful to have patients follow the decontamination protocol, having them place Bactroban ointment in the nose four times a day, five days before surgery, to mitigate against methicillin-resistant *Staphylococcus aureus* (MRSA).² If the patient has a personal history of this bacteria in their nose, the appropriate intravenous antibiotics can be given instead of the usual preoperative antibiotics which include cefazolin or clindamycin.

The Enhanced Recovery After Surgery (ERAS) protocol provides a smoother recovery with less discomfort.³

Any history of sleep apnea is important and should be worked on with a sleep study and a consult with a sleep apnea specialist. Unrecognized sleep apnea can have devastating consequences in the postoperative period after rhinoplasty.

Before the procedure, go over the photographs thoroughly with the patient to make sure expectations are realistic according to your capability as a surgeon. Make sure all

photographic consents are signed and understood to include in the patient's chart, future educational lectures and possible social media posts.

At the beginning of the procedure make sure the patient's eyes are protected by methods such as antibiotic ophthalmic ointment, temporary suture tarsorrhaphy, sterile tape strips, transparent adhesive film dressing either alone or in combination with one another.

Recent literature has suggested that giving 1g of intravenous tranexamic acid (TXA) at the beginning of surgery is very beneficial to decrease bleeding, bruising and pain.⁴ Tranexamic acid inhibits plasmin which prevents the degradation of fibrin clots which decreases bleeding and subsequent bruising. Additionally, inhibiting plasmin inhibits the inflammatory cytokine cascade which reduces the inflammatory component of pain.

The usual dose for preoperative tranexamic acid is 1000 mg (10mg/kg) in a 250ml bag of saline and given slowly intravenously over 20 minutes to avoid hypotension. This is the formula that Dr. Bahman Guyuron uses and if he notices additional bleeding during surgery, he will give DDAVP 0.3 µg per kilogram.⁵

Another good reason to use tranexamic acid instead of DDAVP at the outset is that tranexamic acid costs \$30-\$40 per 1,000 mg vial (10ml vial) and DDAVP costs approximately \$900 per preoperative infusion. These doses of tranexamic acid (10mg/kg) are extremely safe compared to doses given by other specialties such as cardiothoracic surgery and trauma surgery which are 100mg/kg.

Other methods to decrease bleeding and provide excellent visualization in the operative field include using a 1% solution of tranexamic acid mixed into the local anesthetic injection. Additionally, a 3% topical solution of TXA can be used on neurosurgical pledgets placed within the dissected nasal septum, the nasal dorsum and underneath the open septorhinoplasty flap to provide excellent visualization. This is very important not only to the beginner, but it provides excellent visualization and teaching videos for the masters in rhinoplasty. The 3% topical solution of TXA can be irrigated through the 2mm osteotome puncture sites and provide excellent control of bleeding after osteotomy. Many of my patients have absolutely no bruising after extensive osteotomies. The different solutions for TXA in rhinoplasty can be found in Table 2.⁶

Table 2 for Rhinoplasty

1% Tranexamic acid solution:

- 9 ml local anesthetic with 1 ml of tranexamic acid (10 ml total)
or
- 18 ml of local anesthetic with 2 ml of tranexamic acid (20 ml total)
or
- 27 ml of local anesthetic with 3 ml of tranexamic acid (30 ml total)

3% Tranexamic acid solution:

- 21 ml local anesthetic with 9 ml of tranexamic acid (30 ml total)

A few final points on open septorhinoplasty include closing as much dead space as possible. For example, when closing the open septorhinoplasty flap it is important to suture the SMAS tissue down to the anterior septal angle tissue to close off the dead space in the supratip region to avoid pollybeak.

Using silastic splints with breathing holes post-operatively is much more comfortable and safer for the patient than nasal packing. Nasal packing has been associated with toxic shock syndrome and it should be avoided. The dorsal nasal splint should be checked at one week to make sure there is contact with the dorsal skin.

In the postoperative period, it is important to continue the ERAS protocol and have the patient take nonsteroidal anti-inflammatory agents and acetaminophen and avoid narcotics if possible.

Of course, there are many other patient safety pearls which are addressed in technical points by the rhinoplasty masters. It is beyond the scope of this article to address all of these points; however, the recommendations set forth in this article can be used by novices and masters to improve the clarity of the surgical field and provide for a more precise and safer rhinoplasty operation.

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76. **TURKEY**
Turkish Society of Aesthetic Plastic Surgery (TSAPS)
77. **UKRAINE**
Ukrainian Association of Plastic, Reconstructive and Aesthetic Surgeons (UAPRAS)
78. **UKRAINE**
Ukrainian Society of Aesthetic Plastic Surgeons (USAPS)
79. **UNITED ARAB EMIRATES**
Emirates Plastic Surgery Society (EPSS)
80. **UNITED KINGDOM**
British Association of Aesthetic Plastic Surgeons (BAAPS)
81. **UNITED KINGDOM**
United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)
82. **UNITED STATES**
American Society for Aesthetic Plastic Surgery, Inc. (ASAPS)
83. **VENEZUELA**
Sociedad Venezolana de Cirugía Plástica, Reconstructiva, Estética y Maxilofacial (SVCPREM)
84. **VIETNAM**
Vietnamese Society of Aesthetic and Plastic Surgery (VSAPS)

FEATURE

A LONG GOODBYE



CATHERINE FOSS - UNITED STATES
ISAPS Executive Director

In late April, 2019, the President, Treasurer and I had a three-hour long dinner at a lovely restaurant in Val d'Isere, France during the annual SOFCEP meeting. We enjoyed a lively discussion concerning many strategic issues, all to benefit ISAPS, over an excellent dinner with local wine. Near the end of the evening, I mentioned that I had decided I would not renew my six-year contract as Executive Director of ISAPS. It was my time to step down. I was approaching 70, ISAPS would benefit from new blood, and I had served the organization for twenty-two years. This decision, now, would provide the Board sufficient time, nineteen months, to find a successor and to allow a smooth transition.



Figure 1: My favorite photo, taken at the 2014 Congress in Rio, with my dear friend Alison Thornberry, head of the ISAPS Insurance program.

Growing up as an only child in the US, with Czech parents and speaking only Czech at home, I had a special affinity for people “of the world” – not just my school friends. My father’s executive position as the first North American employee of

Alitalia meant that we travelled the world a great deal. My years of competitive skiing also meant months of summer training in Australia and Christmas in Austria every year for more training. I studied French, German and Italian in school and felt at home among people of other nationalities. Later, when interviewing staff to work for me, I would always ask if they had studied any foreign language in school. It gives one a special appreciation for other cultures.

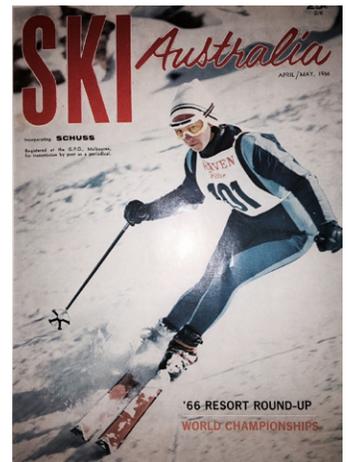


Figure 2: Skiing was my first passion.

I’ve always been an organizer, often creating little “clubs” for my childhood play groups. As a soprano and board member of the Handel Society Chorus of Dartmouth College, I arranged an invitation from Skitch Henderson, the Director/Conductor of the New York Pops Orchestra, for the chorus to perform in the Pops’ 1991 Christmas Concerts in Carnegie Hall. Planning the trip from Hanover, NH, to take 365 singers and their families 300 miles to New York City required a great deal of organizing, some not insignificant politics, and I loved it. So did the rest of the chorus.

My first exposure to ISAPS occurred at the annual conference of the Northeastern Society of Plastic Surgeons in Bermuda in 1997. I was the Executive Director. While we were there, I was invited to a private meeting with **Bill Little** and

Tom Davis who encouraged me to consider joining ISAPS which had never had any administrative support since its founding in 1970. They needed someone to create a centralized office that remained constant. My previous experience managing other societies of which Bill and Tom were members gave me the credibility to undertake this task. I was of course honored to be asked, and was subsequently hired.

When the Board of Directors agreed to hire my company, Bill Little gave up the meager “salary” he was paid at the time to serve as the ISAPS Secretary General in order to pay me instead. He was doing everything personally to manage the society – as did every other Secretary General before him – and I would now start to take on some of those responsibilities as had long been suggested by previous Board member **Freddie Nicolle** (UK). My first responsibility was to assist **Tom Biggs** in organizing an ISAPS Course in Napa, California, preceding the IPRAS Congress in San Francisco in June, 1999.

Since I began working with ISAPS, the membership has grown from 800 to 4,700 members in 110 countries. I have served under 12 presidents, and helped plan 11 Biennial Congresses in Japan (2), Turkey, Brazil (2), Australia, Switzerland, and the United States (3) – and the postponed Congress in Austria.



Figure 3: With Bill Little in San Francisco in 1999.

Some of my ideas for Congress social events came from interesting coincidences. Serving as the Executive Director of IPRAS (2002-2009), I attended their Congress in Sydney, Australia in 2003. The fabulous, over-the-top gala reception in a series of three dockside warehouses that the local committee had organized gave me the idea to do something similar during the ISAPS Congress in Melbourne, five years later. We hired the new Flemington Racecourse clubhouse, took people there by train (12 minutes from the Convention Center) and had a

series of ever-changing entertainments and food stations going on all night – including wallabies, giant snakes, kookaburras, and koalas for people to hold. Even Dame Edna made an appearance. (Sort of.)

During a preliminary visit to Geneva, to plan the 2012 Congress, as we drove through the city wondering what venue would be big enough for a gala event, we passed a park with a circus tent. I thought to myself, could we use the circus tent? And we did. Circus Knie was founded in 1803 by the Knie family and we filled their tent with Congress attendees and families for a spectacle that will be long remembered.

I have travelled to many Board meetings, ISAPS Courses, and other societies' meetings around the world – and made many friends. Having ISAPS exhibits at these courses and meetings promoted membership and created “the face of ISAPS.” It also provided a meeting place for members and a source of information for potential members.

A visit to Jordan to attend one such ISAPS course led to a meeting with Jordanian army officials who controlled the hospitals, which led to an agreement to send our humanitarian teams to Amman in order to help victims of the war in Syria. Through a collaboration with the LEAP Foundation in Texas, we ultimately sent 18 missions to Amman to do 263 surgeries and 450 patient evaluations between October 2013 January 2017. In total, we deployed 25 missions to Jordan, Turkey and Lebanon to complete 438 surgeries and 907 patient evaluations. Stemming from work I did in 2010 to coordinate donations to help the earthquake victims in Haiti through the LEAP Foundation, and a prescient dinner conversation with **Tunc Tiryaki** during a faculty dinner on a river boat in St. Petersburg during an ISAPS Course there, our humanitarian program grew to become a flourishing and very effective effort, for a time. Staff changes at the LEAP Foundation caused them to withdraw from our

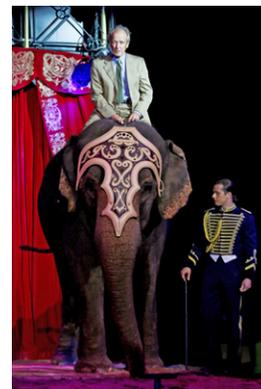


Figure 4: President Jan Poell enters the arena astride a Circus Knie elephant.



Figure 5: Visiting Petra while in Jordan. Don't miss this.

collaboration, which ended our missions as we needed the infrastructure they provided. Today, there are several ISAPS members running other humanitarian programs who welcome our members to join them.

I worked hard over the years to build our family of National Secretaries who now number 108. I was responsible for the transition from a casual group to an important and necessary part of our organization. I introduced, and taught, training programs during the all-day meetings that were now held during each Congress. Less formal gatherings began to occur whenever there were National Secretaries attending other meetings. The National Secretaries meeting at our Biennial Congresses, a valuable opportunity for discussion that also promoted unity among the group, eventually grew to include members of the Board and Committee Chairs to help the National Secretaries in their roles and responsibilities. I wrote the National Secretaries Handbook, a now 40-page “how to” reference in its 11th edition. And of course, I kept track of and managed National Secretary elections each year. Being a National Secretary has a certain prestige that is well deserved for the work this group does year-round. Their dedication to ISAPS is exemplary. Without them, we would not have the membership we have today. They should be appreciated for their dedication to ISAPS, and the true camaraderie that exists among them.

Supporting each President, and every Board of Directors, has been my primary purpose. Coordinating two annual face-to-face Board meetings, one in the US and the other usually in Europe, involved managing agendas, securing meeting space and technical support, hotel reservations, meal planning, meeting minutes and follow-up. Working with the Board and various Committee Chairs to accomplish what was necessary became the day to day focus. These Board and Executive Committee meetings are now of course done via Zoom calls and have become more frequent as would be expected in a growing organization.

Following up on a vision of President **Joao Sampaio Goes** in 2005, I eventually succeeded in creating what is now the ISAPS Global Alliance consisting of 84 National Societies. A few early attempts to bring together Presidents of these societies during ISAPS Congresses did not achieve the expected result. Starting in 2015, I began asking societies to sign a simple, formal Agreement and held another meeting of this group, over lunch, during the Kyoto Congress in 2016. Twenty-two presidents attended that lunch meeting and the concept finally

took off. The purpose is to provide a forum for the leaders of global societies to discuss issues they face at the top level, to work on solving problems together, and to promote and protect the plastic surgery specialty.

Serving as the Managing Editor of *ISAPS News*, with a mission to expand and improve this publication, is an accomplishment of which I am most proud. It has been my pleasure to work with two Editors-in-Chief, **Peter Rubin** and more recently **Nina Naidu**, our assistant **Cheyenne Ziermann** and our very talented designer, **Doris Pfifferling**, to bring the newsletter to its current level. Special thanks to **Riccardo Mazzola** for his participation as the Associate Editor for the History of Medicine. His always eagerly anticipated, fascinating articles on the history of medicine and surgery are so special, coming as they do from research conducted in his vast personal library. We owe special thanks to all the authors who contribute their work to every issue as well as our advertisers and Global Sponsors who help support its production.

I have very much enjoyed working with our current marketing team headed by **Barbara Boeld** in Munich, Germany. Their outstanding work to help expand the ISAPS brand through beautifully designed materials, including our newsletter, and our multiple social media platforms, has been remarkable. They have also been instrumental in producing the first ISAPS Olympiad in September and our near weekly webinars all year to replace our usual courses. The technical support required for these efforts cannot be underestimated.

Kai Schlaudraff and **Alison Thornberry**, who manage our insurance program, have worked tirelessly behind the scenes to create a unique, global product for ISAPS. My commitment to an ISAPS insurance program started more than ten years ago when I was approached by the Senior Vice President of AIG. She was astonished to hear presentations by two ISAPS members at an early conference on Medical Tourism. They were the only speakers in a three-day conference to mention the potential risks to patients seeking less expensive surgery abroad. The Senior Vice President asked me to have a coffee with her in the hotel lobby, and after a two-hour discussion, the seed of an idea to create a global insurance program was planted.

As ISAPS' mission of Aesthetic Education Worldwide® is to improve patient safety, I applaud the work of our Education Council and the Resident Committee. They plan not only the Biennial Congress, but countless courses, symposia, webinars

and our Visiting Professor Program. They are responsible for various training options for Residents as well as endorsing many educational activities submitted for ISAPS' approval from around the world. Maintaining the expanding calendar of these programs on our website, with announcements in monthly eblasts and our journal and newsletter has been an ongoing routine. Adapting to new ways to provide this education using technology that did not even exist a few years ago shows how adaptable ISAPS is. We owe a debt of gratitude to the leaders of the Education Council and to the staff working behind the scenes to produce these educational events.



Figure 6: With Tom Davis during a Board meeting in Lugano, Switzerland.

A guiding light for me during my entire tenure with ISAPS has been **Tom Davis**. I knew him for years before coming to ISAPS.

He was instrumental in my taking on the Executive Director position with the previously mentioned Northeastern Society of Plastic Surgeons – a position that I held for 18 years. He has served in so many different ISAPS Board and Committee positions and has been the memory of ISAPS – and thus a keeper of the traditions. No one has served ISAPS longer than Tom. His support and friendship for all these years is much appreciated.

Not to be omitted – my staff. Many have come and gone during the thirty-eight years that I have owned my company, and they all contributed to the success of ISAPS. There were never more than six of us in the office which still amazes me given how much work we were able to accomplish, year after year. **Michele Nilsson** and **Sean Finnell** continue to provide an immense level of support to me – and to ISAPS – during this current transition. Many others work hard in the background, if not every day, providing IT, financial, and legal support. I could not have done what I did without all of them.

Over time, ISAPS became my passion, my focus, and my family. I got married, then divorced, and ISAPS was always the constant that gave meaning and purpose to each day. It has been so much more than “a job.” Thus, it is that much more difficult for me to say goodbye to all of you now. I look forward to retirement. My plan was to travel, but that is necessarily on hold – although I have scheduled (and paid the deposit for) a fantastic 16-day safari in Africa next summer with a dear friend. I have most of Africa and Asia yet to explore.

In the languages I know, Au Revoir, Auf Wiedersehen, Arrivederci, Adios, Nashledanou and Ahoj. And of course, Goodbye. I will miss you all – more than you know.

SHORT CASE STUDY



BABIS RAMMOS
UNITED STATES

BREAST LIFT WITHOUT IMPLANTS

INTRODUCTION

Patients who present with enough breast tissue can benefit from a Wise pattern mastopexy without an implant. These patients usually present with Grade II or III ptosis, vertical and horizontal skin excess, and their goal is reshaping and contouring their breasts while elevating the nipple and achieving a fuller appearance. Physical examination focuses on current breast size, degree of ptosis and any breast asymmetries.

MARKINGS

The patient is marked in the upright standing position, and the following markings are made:

- The new nipple location is marked by transposition of the inframammary fold to the front of the breast, at the level of the meridian.
- The top of the areolar opening is marked 1-2 cm above the new nipple position. With the use of a keyhole breast reduction marker (42 mm), the areola opening is marked.
- The breast is displaced, first laterally and then medially. Vertical lines are drawn from the lower portion of the new areola to a point 1 cm above the inframammary fold.
- Measurements are made bilaterally, from sternal notch to nipple, and from midline to ensure symmetry (*Figure 1*).

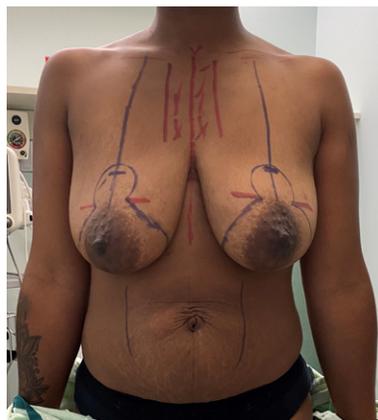


Figure 1: Preoperative mastopexy markings.



Figure 2: The nipple areola complex is left in situ, and the intervening skin is deepithelialized.

TECHNIQUE

The patient is brought to the operating room and placed in the supine position on the operating table with the arms extended up to 90 degrees and well secured to the arm boards. Both shoulders should be at the same height. The patient placed in an upright seated position to evaluate the preoperative status. A mastopexy is performed using the Wise pattern technique with a horizontal scar. The nipple areola complex is left in situ,

and the intervening skin is deepithelialized (Figure 2). A superior pedicle is created, and an appropriate vertical and horizontal amount of tissue is removed, and recorded. The lower areola to inframammary fold distance is chosen on average at 7 cm. Vertical pillar sutures are placed, and the wounds are closed in layers. After conclusion of the procedure, the patient is placed again in an upright seated position for final appreciation.

RESULT

This 28-year-old female presented with breast ptosis and desire for a breast lift without an implant (Figures 3a, 3b). A superior pedicle mastopexy was performed. She was pleased with her postoperative outcome (Figure 4).

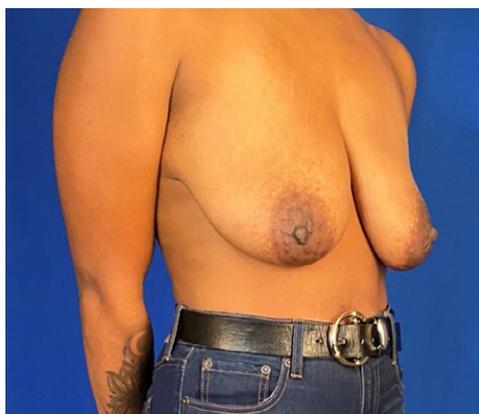


Figure 3a: Preoperative frontal view of a 28-year-old female with breast ptosis.



Figure 3b: Preoperative right oblique view of a 28-year-old female with breast ptosis.

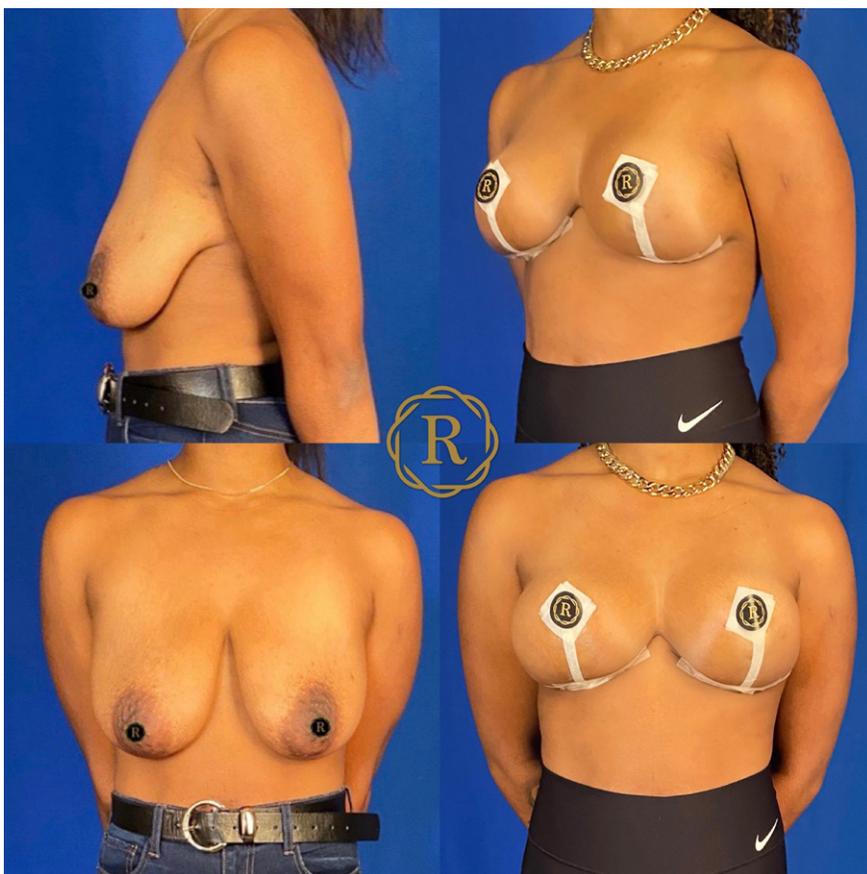


Figure 4: 1-month result after bilateral superior pedicle mastopexy without implants.

IN MEMORIAM

SURESH CHANDRA GUPTA (1933-2020)



SURESH CHANDRA GUPTA
INDIA

Dr. Gupta was born on 5 October 1933. He did his early schooling at Modern School, Delhi and FSc from Aligarh Muslim University, Aligarh. He completed his MBBS with Gold Medal & Honors in 1955 and MS (surgery) in 1958 from Agra University. He worked in the UK from 1960 to 1965 and upon returning to India, he worked as a Senior Honorary Consultant in Plastic Surgery at Maulana Azad Medical College and associated hospitals in Delhi. In 1968, he joined Sir Ganga Ram Hospital where he established the plastic surgery department and remained its head till his retirement in 2002. Even post retirement, he continued to work as an Emeritus Consultant and was active even through the current COVID times. He was the recipient of numerous awards, fellowships, orations, professorships and honorary positions.

From 1965 onwards, he made immense contributions to the Association of Plastic Surgeons of India (APSI) as a member, Executive member, Secretary, Treasurer, Editor and finally President in 1977. In 1987, he organized the 9th International Congress of the International Confederation of Plastic Surgeons in Delhi and also presided over its 15th World Congress in 2009 in Delhi.

His zeal for both teaching and learning were unparalleled. He established microvascular surgery in North India by performing

the first free groin flap in Railway Hospital, Delhi and later setting-up in animal lab in Sir Ganga Ram Hospital. He was a regular faculty member at all APSI meetings which he rarely missed.

He made immense contributions to the practice and teaching of aesthetic surgery in India, and along with a few others, was one of the founders of the Indian Association of Aesthetic Plastic Surgeons (IAAPS) in 1995 in New Delhi. He was one of the earliest members of ISAPS from India and actively participated in almost all meetings even at the age of 87.

He passed away on 4 November 2020 at the age of 87. He must have had a premonition, as he wrote a letter in January 2020 which starts with "I am writing this to say that as now my innings are coming to a close, I should reflect on my contributions to the Association."

He is survived by his wife, two daughters, a son, their spouses and grandchildren. May his soul rest in eternal peace and may God give courage to his family to bear this loss.

God bless the late Dr. Suresh Gupta.

*Manoj Khanna - MBBS, MS, MCh, DNB, FICS
ISAPS National Secretary for India*

IN MEMORIAM

JUAN CARLOS SEILER (1944-2020)



JUAN CARLOS SEILER
ARGENTINA

Dr. Juan Carlos Seiler (Argentina) passed away on October 19, 2020. He was married 50 years ago to his lifelong partner Graciela. From this union, his children Federico, Verónica and Juan Ignacio were born, who in turn gave him five grandchildren.

Charly, to his friends, had a fruitful career both in healthcare and in the corporate field. He studied medicine at the University of Buenos Aires and completed his residency in General Surgery at the Rawson Hospital also in Buenos Aires. He began his activity as a plastic surgeon in Room 7 of the Rawson Hospital, continuing it in the Churruca-Visca Police Hospital (1973-1985) and from 1985 in the plastic surgery service of the German Hospital where he attended until a few days before becoming ill.

His corporate activity was very important with participation in multiple national and international congresses and symposia presenting papers and coordinating and directing roundtables on various topics of plastic surgery. He was president of the

Buenos Aires Society of Plastic Surgery in 2003, Director of the XXI Century Symposium in 2004, and president of the Argentine Congress of Plastic Surgery in 2010, which was called the bicentennial congress.

He was also an ISAPS National Secretary for Argentina and designated a National Honorary Member of the Argentine Medical Association.

Charly was a lover of sports, travel and music, being a regular at the Teatro Colón, and enjoyed friendship and family life. I am grateful for having had a friend like Charly who was always characterized by his willingness to conciliate in the face of any kind of conflict.

We are going to miss you, dear Charly.

Rest in Peace.

Enrique Pedro Gagliardi, MD, PhD

NS CHAIR REPORT

HOW COVID-19 EMPOWERED THE NATIONAL SECRETARIES FAMILY NETWORK



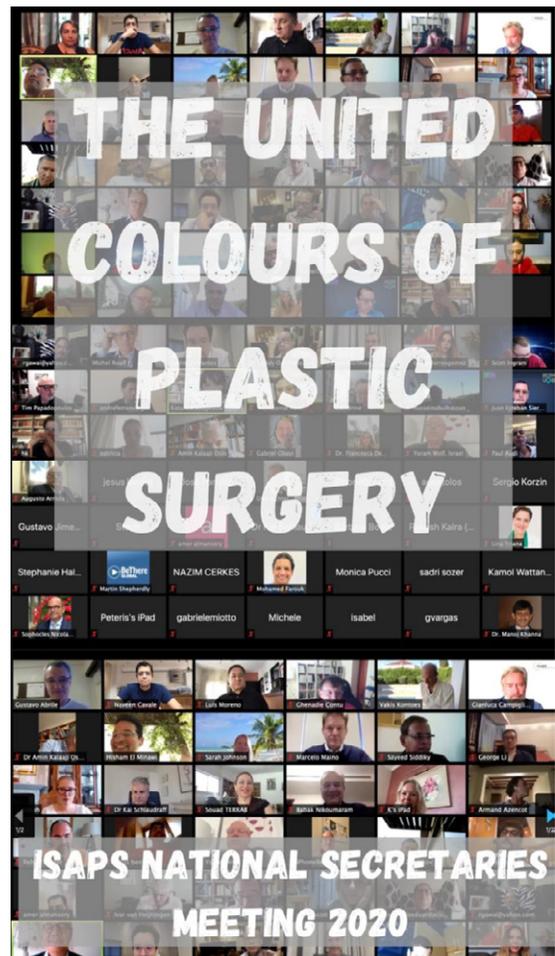
MICHEL ROUIF - FRANCE
ISAPS Chair of National Secretaries

The network of the ISAPS National Secretaries' (NS) family had its first "Online Global Meeting" on the 21st of August 2020. About 85 NS and Assistant National Secretaries (ANS) met all together, but also shared the event with the ISAPS Board of Directors (BoD) through our ISAPS digital platform.

Thanks to this new technology, we were able to experience new possibilities in team working. This first "National Secretaries Meeting ISAPS BoD" was actually a wonderful opportunity to test and extend the possibilities of the platform we have been using for months for ISAPS Master Class webinars. The program was really exciting.

During one hour, the Board presented how ISAPS is facing the pandemic, all over the world; what the financial concerns are for ISAPS (humanitarian committee included, with COVID and Beirut explosion); how the Board is managing the postponed biennial meeting in Vienna, and also the new Olympiads; and what the new trends are with membership. After Dr. Dirk Richter's presentation, Dr. Nazim Cerkes, ISAPS President 2020-2022 detailed his program. This was a great opportunity to inform the National Secretaries, and indirectly the members, about By-Laws changes, the voting process through our new tool - in one word, what is coming in ISAPS in the next months.

For the two next parts, we moved to the new digital world. As we wanted to be able to discuss together, these parts



were set up in order to have small groups for discussion. We were able to switch in a few seconds to smaller working groups with a NS as Chair, a board member and around 13 NSs in each group.

The second part (45 minutes) was led by Andre Cervantes (Brazil NS), Chair of Continental Communication Committee. The goal for this part was to address more specific questions in each continent. I thank Andre and the National Secretaries who were chairing: Jose Carlos Parreira (NS Portugal) for Europe, Teddy Prasetyono (NS Indonesia) for Asia Pacific, Montserrat Fontbona (NS Chile) for South America, Gabriele Miotto (NS USA) and Bertha Torres (NS Mexico and ISAPS Assistant NS Chair) for North & Central America and Reha Yavuzer (NS Turkey) and Souad Terrab (NS Morocco) for Middle East and Africa. A report was given then by each of the Chairs to the Board of Directors.

The final part was based on a Survey Monkey survey launched a few weeks before to the National Secretaries. All NS were divided, according to their preferences, into four groups via the Zoom Breakout Room function to discuss during 20 minutes four relevant questions to the ISAPS Committees. One board member was invited in each group to listen to the discussions and get insights on the topic. Each group had five minutes to present a summary of their queries in the plenary session.

I want to thank the National Secretaries for the great work they did, preparing these four meetings and chairing these four groups.

- Education Program: Education program in countries, collaboration with national societies. Chair Hisham El Minawi (ANS Egypt) inviting Vakis Kontoes (Education Council Chair) and Ozan Sozer (Education Council Vice-Chair)
- Membership and development, marketing to surgeons (Process of application, tools to promote membership, Fast Track). Chair Argentina Vidrascu (NS Romania) inviting Fabian Cortiñas (Membership Committee Chair)
- Communication, marketing to patients in their countries. Chair Katarina Andjelkov (NS Serbia) inviting Tim Papadopoulos (Parliamentarian, ISAPS website director)
- COVID-19 pandemic and humanitarian program. Chair

Jesus Benito (NS Spain) inviting Nina Naidu (NS US and Humanitarian Committee Chair)

During these first 20 minutes, the Continental Communication Committee was continuing the conversation with the other board members.

The time was all too short, but we worked very quickly, all together, and opened doors for further discussions, raising new ideas from the NS, involving them in the construction of ISAPS, giving to all the participants the opportunity to better understand the concerns of everyone's tasks and responsibilities.

I would say that the technical team worked very well with all of us, thanks to the new digital functions we have. It was a wonderful experience and the discovery of fantastic future possibilities. In a few seconds, we were "transposed" from a main room to small ones and then all back 20 minutes later. And, we didn't lose anyone in the digital corridors. Efficiency was there. We left this two-and-a-half-hour meeting with numerous new ideas for ISAPS, without wasting time, money and energy on planes, airports and trains.

For sure, we definitely need to meet ourselves in the real world, to spend more time together, to have a drink - champagne for the 50th ISAPS birthday - or dinner - but what we did, because of COVID, was to adapt ourselves to a critical time. And finally, we did it differently and maybe we made more progress.

Let's go for the next one in January 2021. Our challenge for 2021? To set up 3-4 meetings during the year in order to improve the circulation of information among the BoD, the NSs, and ISAPS members, in real time!

As Darwin wrote, "It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change."

Be safe with friends and family.

I love this Family!

SPOTLIGHT ON NATIONAL SECRETARIES



LUIZ S. TOLEDO - LISBON, PORTUGAL AND DUBAI, UNITED ARAB EMIRATES
ISAPS National Secretary UAE

Why did you run for this position, how long have you served as a National Secretary, and what are your goals in this role?

I have been a member of ISAPS for 37 years (since 1983), attending my first ISAPS congress in New York in 1987, and have always played an active role in the organization. From 1997 to 2000, I was elected National Secretary for Brazil for two terms. During this time, I was also a member of the Organizing Committee of the ISAPS 14th International Congress in São Paulo, Brazil in 1997.

I was an ISAPS Course Director from 1994 to 2000, responsible for organizing courses in several countries and continents. During my time as Course Director, I invited many Brazilian surgeons to be part of the course faculties, giving them a chance to show the international community the Brazilian expertise in the field.

From 2000 to 2006, I was asked to initiate the Public Education Committee and was responsible for executing and publishing the first six International Statistics on Aesthetic Plastic Surgery. It was done by fax then. This was something the media always had great interest in and it helped each member to promote the specialty in their country.

In 2006, I moved to Dubai. In 2013, I became Scientific Director of the Emirates Plastic Surgery Society (for 6 years). I was also elected ISAPS National Secretary for the UAE and am now in my second term. This allowed me to organize the first ISAPS Course in the UAE in 2014 and subsequently organize three ISAPS sponsored congresses in 2015, 2016 and 2017 held in Dubai.

These should be the goals of National Secretaries - working in conjunction with their local plastic surgery society for the educational benefit of its members.

What are some of the main concerns for plastic surgeons in your country and how can ISAPS best help you and your colleagues address these issues?

Recently, the UAE has seen a disproportionate increase in the number of plastic surgeons and non-plastic surgeons moving to and working in the region. This has created many problems due to the diversity of training. ISAPS needs to have a campaign, teaching patients the benefits of choosing a properly trained surgeon and to identify the qualifications that are necessary to become a specialist in plastic surgery.

What new initiatives would you like to see ISAPS undertake?

We could think about organizing a congress in the Middle East. Dubai made a bid for the 2020 ISAPS Congress, but, according to the rules, the congress had to be in the country of the president, Germany. The Congress was later moved to Austria (not the same country, but the same language) and subsequently ended up being cancelled because of COVID. Now with the trend of online meetings, maybe ISAPS will have more congresses, instead of the traditional biennial. We could think of the Middle East as a host.

What led you to specialize in plastic surgery?

From the age of five, I remember wanting to become a doctor. My uncle was a very well-known Harvard graduate pediatrician in São Paulo and his standing and profession filled me with awe as a young child. In my sixth year of medicine, I met and

started working with my professor and mentor, Dr. William Callia, one of the best plastic surgeons in São Paulo at the time. It was love at first sight with the profession. In 1970, Brazil had around 60 plastic surgeons. Plastic surgery was still a new specialty.

Tell us something about your outside, non-professional, interests?

Photography is one of my passions and with the inevitable slowdown resulting from COVID, I have been able to pick up

this obsession of mine with a little more time on my hands now. I also have more time to write, another hobby of mine, having also worked as a journalist for several Brazilian magazines during my time. I am an Elizabeth David fan and enjoy cooking and entertaining. Travel of course tops the list.



MONTSERRAT FONTBONA - CHILE
ISAPS National Secretary, Chile

Why did you run for this position, how long have you served as a National Secretary, and what are your goals in this role?

I have been an ISAPS member since 2010. During Dr. Teresa de la Cerda's periods as National Secretary, I worked with her organizing three ISAPS Symposia in Chile (2015, 2017 and 2018) and giving our members the possibility to have outstanding international professors in our country to learn from them and to share very good moments together. Since 2018, I have been part of the Continental Communication Committee representing South America and also part of the Education Council. This year, I was elected National Secretary for Chile. My goals in this role are to have more Chilean members in ISAPS (I have already enrolled most of the residents in Plastic Surgery in Chile), to give more opportunities to our members to participate actively in ISAPS as professors or in the organization of activities and also in the scientific events organized by ISAPS. I'm also trying to be a fluid communication channel between ISAPS and these members, so they can feel more engaged.

What are some of the main concerns for plastic surgeons in your country and how can ISAPS best help you and your colleagues address these issues?

Some of the main concerns for plastic surgeons in my country are:

- Intrusion of non-plastic surgeons due to the lack of legislation in this field
- Poor regulation of our specialty
- Lack of knowledge among the population of certified plastic surgeons

I think ISAPS could get more involved in local instances of defense of the specialty, giving more support to our National Society, and also in the education of patients, maybe with advertising campaigns in Spanish that can be shared on social media.

What new initiatives would you like to see ISAPS undertake?

New initiatives I would like to see are medical marketing training, ISAPS social media in Spanish, improving the visibility of ISAPS members in each country, and supporting the defense of the specialty.

What led you to specialize in Plastic Surgery?

In my childhood and adolescence, my father taught me to build different scale models of ships, cars and house facades and I liked to build things with my hands and also the concentration and accuracy required. Moreover, my mother is a nurse and we have a strong relationship. Maybe both have partly influenced my decision to be a doctor, and to be a plastic surgeon: a specialty in which we can help others to heal or build their lives in a visible way.

Tell us something about your outside, non-professional, interests?

One of the things I most like is to travel to different places and countries and I enjoy seeing interesting sites, having new experiences, and tasting different foods. To have the opportunity to travel with my family makes the experience even better.



MANOJ KHANNA - INDIA
ISAPS National Secretary, India

Why did you run for this position, how long have you served as a National Secretary, and what are your goals in this role?

In 2015, I was the President of the Indian Association of Aesthetic Plastic Surgeons (IAAPS) and Lokesh Kumar, the ISAPS National Secretary for India, was finishing his second term. Lokesh had conducted three ISAPS courses, all of which I attended, and felt that if I took over the responsibility, I could do a good job for the aesthetic surgeons in our country. Also, Lokesh was running the ISAPS Courses individually out of the National Indian Association and I always felt that IAAPS must be integrated and actively involved in all ISAPS courses in our country, and that was my big drive for seeking election. Fortunately, I won comfortably and was elected in 2015, and did a decent enough job to be re-elected in 2019 for my second term. I want education in aesthetic surgery to be of the highest standard in our country and feel that ISAPS can be the only medium that will allow us to go about achieving that. I am the earliest member of ISAPS in India and am happy with the progress being made due to the contribution of ISAPS towards education in aesthetic surgery in our country today.

What are some of the main concerns for plastic surgeons in your country and how can ISAPS best help you and your colleagues address these issues?

Training in aesthetic surgery is extremely limited during Residency in our country. ISAPS is the best platform for all aesthetic surgeons in India, youngsters and the matured seniors, to improve our knowledge and skills to be at par with the best standards anywhere in the world.

What new initiatives would you like to see ISAPS undertake?

I am very happy with the induction of Resident members into

ISAPS. I would like more academic content, especially videos to be available to all members so that we can learn and go back and refer to their content whenever required to produce results as good as anywhere in the world.

What led you to specialize in Plastic Surgery?

I was good in anatomy and decided to opt for surgery. During my Residency in surgery, I was fascinated by the imagination and fine artistic skills of plastic surgeons, and immediately decided to take up the specialty.

Tell us something about your outside, non-professional, interests?

I have a lot of activity outside my profession. I have been an active cricket player, played at a good level, and was captain of a combined national Indian Medicos cricket team in 1984. I still play more than 10 cricket matches every year with distinguished performances. I have travelled all around our country and the globe to watch international cricket matches and do so even now.

At the age of 44, I took up tennis, have been playing regularly, and have been the current veterans 45+ doubles champion for tennis in our state for the last four years. I am 61 now and my doubles partner, Ram Kumar, a fantastic tennis player, turns 55 this month. We aim to be the national doubles veterans 55 + champions of our country in 2021.

I have been a commentator on our national television network, Doordarshan, for cricket and tennis since 1990. I was privileged to be one of the two English commentators for the live telecast of Mother Teresa's funeral which was the most watched television program anywhere in the world.

ISAPS JOURNAL

MESSAGE FROM THE EDITOR-IN-CHIEF



BAHMAN GUYURON, MD - UNITED STATES

I am pleased to share a progress report with you that has been prepared for us by our publisher. First and most importantly, according to a survey conducted by Springer, the authors' satisfaction rate is 97% with 84% being excellent. It may not be realistic to have a 100% excellent rating, yet we will strive for it.

The average time for the first decision has been reported to be 14 days - the best time amongst 2,900 Springer journals. The second-best time for the first decision is twice as long as our decision time. This, in my opinion, could be one of the most important contributing factors to the high satisfaction level. I share the credit for this colossal achievement with many of you who serve on the Editorial Board or as reviewers. You have been responding to my invitations to review articles with great alacrity and completing the reviews with utmost celerity. Our final decision time as a team is equally short. I extend my deepest gratitude to all of you for your unselfish volunteer work with such amazing efficiency.



The submissions at the end of September surpassed the entire number in 2019 by 20%. Should this trend continue, our submissions will soon double in comparison to what they were when I accepted my position as Editor. While our submissions had increased another 20% before the COVID pandemic, the lockdowns may have had a role in such a significant increase.

Because of this increase in submissions, our need for reviewers has substantially increased, especially for the topic of genital surgery. If you wish to serve as a reviewer, please send me an e-mail.

The impact factor has increased a good deal because of the scientific power of your articles.

I hope you had a chance to read the August issue of the journal that includes a collection of the most referenced and most downloaded articles over the last 20 years.

HISTORY



RICCARDO F. MAZZOLA - ITALY
ISAPS News Associate Editor,
History of Medicine

THE FASCINATING HISTORY OF AESTHETIC RHINOPLASTY

Introduction

The fascinating history of aesthetic rhinoplasty begins in 1845 when Johann Friedrich Dieffenbach (1794-1847), surgeon at La Charité Hospital in Berlin, carried out the first operation for modifying the shape of large, hanging noses¹. No image was provided. The procedure, a mere cutaneous skin excision, was undertaken sometime later by the Latvian surgeon Julius von Szymanowsky (1829-1868) and reported in his “Operatzij poverchnosti...” (Handbook of Operative Surgery)². Szymanowsky supplied the pre- and post-operative illustrations of the procedure emphasizing that correction was done for aesthetic purposes and that the drooping tendency of the tip was improved (Figure 1).

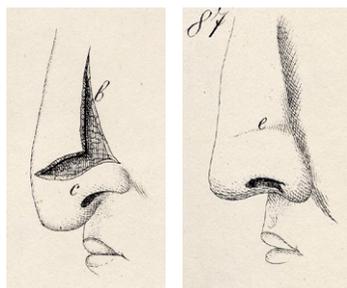


Figure 1: First aesthetic nasal operation for drooping tip correction. From: Szymanowsky J. 1865 (see ref. No.2)

Roe and Weir

It took more than 40 years before someone dared to perform another aesthetic operation on the nose. In 1887, John Orlando Roe (1848-1915) an otolaryngologist from Rochester, New York, who graduated from Columbia University in 1871, presented a paper before the Medical Society of New York on the reduction of a bulbous or “pug nose,” as he termed it, with the specific goal “to improve the personal appearance of an individual”³. Under local anaesthesia, by intranasal approach, Roe undermined the tip of the nose and removed the bulky tissue without injuring the overlying skin. He finally replaced the covering into position and applied a splint to facilitate the healing process. Four years later, in 1891, he presented another paper to the same society for correcting a hump nose or “angular deformity”⁴.

Under local anaesthesia, he made an incision along the columella and undermined the nasal skin widely. Then “he introduced a pair of angular scissors and cut off the projecting piece of bone until the top of the nose was perfectly straight and smooth” (Figure 2). Finally, he pushed the overlying skin down and applied a splint. The above two papers demonstrate that Roe was the originator of aesthetic rhinoplasty.

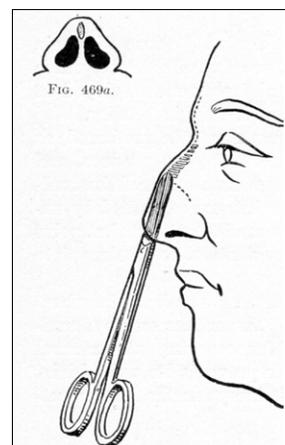


Figure 2: Hump removal, according to JO Roe (see ref. No.4)

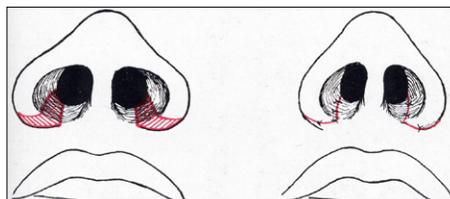


Figure 3: Correction of flared nose, according to RF Weir (see ref. No.5)

The following year, another important step was added into the rhinoplasty scenario by Robert Weir (1838-1927), a general surgeon from New York. Weir published on restoring sunken noses without scarring the face, an account mainly devoted to correct saddle nose deformities⁵. However, in the last part of the paper, the author described a technique for modifying flared noses. He excised a full thickness piece of alar base bilaterally, moved the divided edges more medially and held them in position with a through-and-through stitch traversing the columella. Weir deserves credit for this brilliant idea for nasal surgery. The alar base excision is now eponymically named “Weir Operation” (Figure 3).

Jacques Joseph, life and contributions

In Europe, aesthetic rhinoplasty started in Berlin with Jacques Joseph (**Figure 4**). Born in Königsberg (capital of Prussia) in 1865, Joseph began his career as an assistant in the Orthopaedic Clinic at La Charité in Berlin. In 1896, he performed an operation



Figure 4: Joseph's portrait

for correction of prominent ears, considered offensive to the interests of his department; therefore, he was fired at once. He entered into private practice showing special interest for nasal surgery. Thanks to his great surgical skill, he was able to amass vast experience in a very short time and in 1898 he proudly presented a paper on the operative reduction of the size of the nose before the

Medical Society in Berlin⁶.

The procedure to shorten the nose was by external inverted V incision on the dorsum. Through this approach, he could excise bone, cartilage, lining and a wedge of the caudal septum achieving remarkable results. He thought he was the first to perform this type of operation, but with great disappointment he learned that something similar was done by Roe and Weir a few years before intranasally, without any visible scar. Only

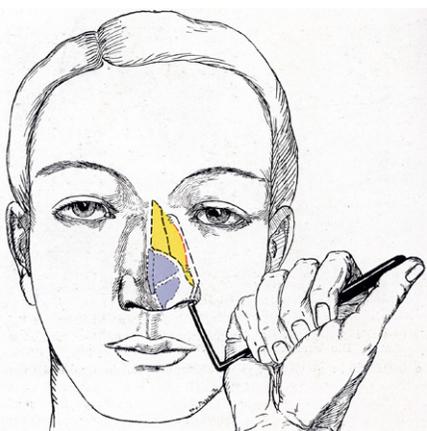


Figure 5: Lateral osteotomy using the saw, invented by Joseph

in 1904 did he publish the first cases of dorsum lowering and narrowing the sidewall of the nose by sawing through the frontal process of the maxilla. The instrument, designed by him, was inserted in a narrow tunnel created in the

outer border of the pyriform aperture (**Figure 5**). From then on, Joseph constantly developed the whole field of aesthetic rhinoplasty. In 1907, he showed how to manage crooked noses⁷.

In 1912, he summarized his achievements and outstanding results (**Figure 6**) in a 50-page chapter for the four volume *Treatise of Otolaryngology* edited by Katz et al⁸. The different

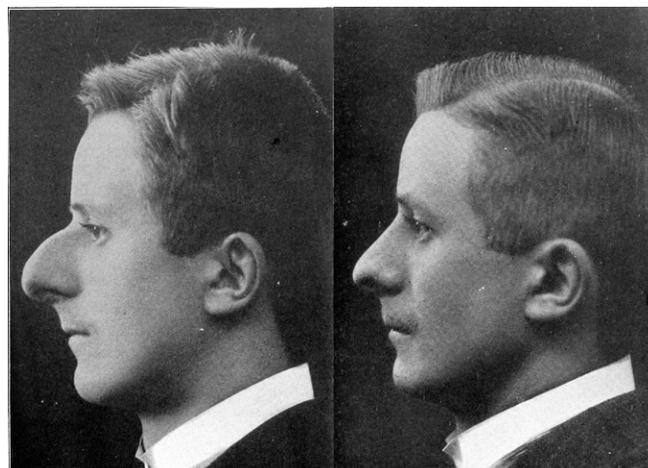


Figure 6: A pre- and post-operative rhinoplastic result by Joseph, published in 1912 (see ref. No.8)

steps of the technique were scholarly presented, from the intranasal approach, to dorsum undermining, hump removal, alar reduction and lateral osteotomy. New instruments were introduced. The paper plays an important role in the history of aesthetic rhinoplasty. It should be regarded as the first comprehensive report on this topic.

In 1916, Joseph was appointed head of the section for facial plastic surgery of the ENT Clinic at La Charité Hospital



Figure 7: Two happy patients dancing after surgery. From Joseph 1931 (see ref. No.9)

in Berlin and devoted himself to the treatment of severely injured patients from World War I. For this outstanding social involvement, the Ministry of Science granted him the title of Professor in 1919. Throughout his long, successful career he operated hundreds of rhinoplasties, systematizing the technique, designing new instruments necessary to perform the procedures or to improve the outcomes, recording and classifying every possible clinical situation regarding the nose, from simple deformities, to post-traumatic cases, to rare congenital anomalies, and complex reconstructive procedures. He maniacally documented the pre- and post-operative appearance of each patient in the same view (front and lateral), at the same distance, using the same lighting and background, evaluating the relationship between nose and face (naso-labial, fronto-nasal and facial angles) and describing the psychologic impact of the operation on patients (**Figure 7**).

He had a brilliant, creative mind, but a very difficult character. He organized well-attended live surgery courses

for foreigners, mainly Americans, at considerably high fees. No chance to ask questions was allowed. If attendance did not include the OR, tuition was cheaper. For at least 20 years, he dominated the rhinoplastic scenario in Europe, receiving the most famous patients from every country and charging elevated



Figure 8: Title page of Joseph's book on Rhinoplasty, issued in 1931 (see ref. No.9)

fees. Very wealthy, he lived in a prestigious villa at Berlin-Wilmersdorf. Joseph's legacy was included in a monumental monograph *Nasenplastik und sonstige Gesichtsplastik* (rhinoplasty and other facial-plasties), published in 1931, which remained an unsurpassed reference point for several years⁹ (Figure 8). Although he was not the first to perform an aesthetic rhinoplasty operation, and it was very difficult, if not impossible for him to admit it, he might

certainly be considered the father of this operation for the fundamental contributions done in this field.

Upset by the restrictions imposed on Jewish physicians by the Nazis in 1933, he died in February of the following year



Figure 9: The author at Joseph's grave at the Jewish cemetery of Berlin Weissensee

under unknown circumstances, possibly coronary disease or suicide. He was buried in the Jewish cemetery of Berlin Weissensee (Figure 9).

Joseph's legacy: rhinoplasty after Joseph

Early 20th century scientific literature revealed that miracles were possible such as changing the shape of the nose by removing a hump or correcting a depression thanks to the "new" aesthetic operations. Surgeons in Europe and the United States began to experiment with nasal reduction procedures and a flood of papers appeared all over the world, although the classic Joseph rigid sequence was universally adopted: intra-cartilaginous/transfixion incisions, lower lateral and caudal septal cartilage reduction, hump removal, lateral osteotomies for narrowing. For at least 50 years, the technique remained basically the only available solution, and is still practiced today in selected cases. During the interwar period, numerous books and individual reports were published everywhere, presenting different authors' experiences or variations on the theme, thus adding a little piece to the complex mosaic of the rhinoplasty.

Probably the first monograph on the subject was *Plastic Surgery of the Nose* by J. Eastman Sheehan (1885-1951) from New York, published in 1925, where the author explains his method of doing the nasal work through a columellar splitting approach and by using chisels instead of saws¹⁰. The book had a great impact on the American culture of beauty. People were aware of the possibility of correcting congenital or acquired deformities, but they were less informed about the newly introduced aesthetic operations, like having a nose fixed. Sheehan, along with Gillies and Ferris-Smith, was one of the three faculty members of the well-attended International Clinic of Otorhinology and Faciomaxillary Surgery in Paris, where courses on facial reconstruction and rhinoplasty were organised on a yearly basis from 1925 to 1928 by the French ENT Ferdinand Lemaître (1880-1958). Sheehan was elected President of the American Association of Plastic Surgeons in 1935, despite the controversial attitude toward him that had arisen from numerous members of the association who regarded him as a skilled operator with particular attention for the media. He was considered a very costly surgeon as he charged fabulous prices - up to \$10,000 for a single operation¹¹. In 1936, Sheehan issued the second edition of his book, where his results were shown using the intranasal approach.

In France, otolaryngologists Pierre Sébilleau (1860-1953) and Léon Dufourmentel (1884-1957) published *Correction chirurgicale des Différences congénitales et acquises de la Pyramide nasale* (Surgical correction of congenital and acquired deformities of nasal pyramid) in 1926. Great emphasis was given to the

improvement of breathing problems associated with the aesthetic outcomes.

The following year Julien Bourguet (1876-1952), a Parisian plastic surgeon, printed *La Chirurgie esthétique des diverses Déformations nasales* (Aesthetic surgery of different nasal deformities), where he showed his results using the Joseph technique, combined with the Weir alar base excision, when needed¹² (**Figure 10**). In 1931, the same year of Joseph's Nasenplastik, Gustavo Sanvenero Rosselli (1897-1974) pioneered the different aspects of nasal surgery in Italy by publishing *La Chirurgia Plastica del Naso* (Plastic surgery of the nose)¹³. In this monograph, along with the numerous cases of nasal reconstructions, he described the aesthetic modifications of nasal deformities, basically following Joseph's procedure.

Gustave Aufricht (1894-1980) and Joseph Safian (1886-1983), both pupils of Joseph, are best remembered for popularising the original Joseph's technique for reduction rhinoplasty in the United States¹⁴. Safian published a book, *Corrective Rhinoplastic Surgery*, in 1935, mainly based on the adoption of Joseph's procedures¹⁵.

He also added some improvements of his own for correcting wide tip by trimming lower lateral cartilage using the double intra-cartilaginous incision.

In 1940, James Barrett Brown (1899-1971), Professor of Clinical Surgery at Washington University, St. Louis, Missouri, contributed to the Nelson's Loose-Leaf Surgery series with an extensive chapter entirely devoted to the Reconstructive Surgery of the Nose, where he summarized the different operations of the nose, from reconstructions to aesthetic deformities.

In 1947, the book by Maliniac, *Rhinoplasty and Restoration of the Facial Contour*, was published, written more for prospective patients than for the specialist. Born in Warsaw, Poland, Jacques W. Maliniac (1889-1976) studied in France at Nancy and Paris. After World War I, he practiced in Paris with Léon Dufourmentel and in Berlin with Jacques Joseph. On moving to the United States, he opened a successful private practice in New York and was one of the founding members of the ASPRS in 1931.

Generally speaking, later monographs although beautifully presented and illustrated with attractive drawings and remarkable photographs, were rehashes or modifications of

well-established procedures. Only recently have significant changes and improvements been developed in the field of rhinoplasty.

Tip projection's enhancement

A drawback of Joseph's technique was the lack of attention given to the tip. Patients often complained that the tip remained broad, round, with poor definition. To overcome the problem,

Irving Goldman (1898-1975) suggested to deliver the dome by a double incision, cut the angle between medial and lateral crura and suture the medial crura together¹⁶. In this way, a good tip projection was undoubtedly achieved, at the expenses of the alar contour, which appeared often pinched. Some important modifications were introduced by other authors later.

Cartilage grafts to the nose: a revolutionary concept

In 1975, Jack Sheen from Los Angeles, California, popularized a revolutionary new concept in aesthetic nasal surgery: the use of cartilage grafts harvested from the septum or concha, to the tip and to the vault (tip grafts and spreader grafts), for increasing tip projection and for balancing the middle third of the nose with the tip¹⁷. For 75 years, rhinoplasty was mainly an excisional surgery to obtain volume reduction. Since then, it has become a combination of excision and augmentation.

The open approach

Jack Sheen was a supporter of the traditional closed approach technique for this type of surgery. On the contrary, other surgeons preferred to perform similar tip work under direct vision, the so-called open or trans-columellar approach, to avoid potential graft displacement and to stabilize the cartilage in the appropriate position with sutures. The technique, pioneered in 1934 by the Hungarian otolaryngologist Aurél Réthi (1884-1976) with the idea of making long noses short and for lowering the dorsum under direct vision¹⁸, fell from favour for the unpredictable results obtained (**Figure 11**). It was revisited and popularised by W. S. Goodman almost 40 years later, in 1973¹⁹. The introduction of the open approach to the nose produced a profound impact on rhinoplasty, gaining continuously new proponents and becoming one of the most convincing advances in recent years.

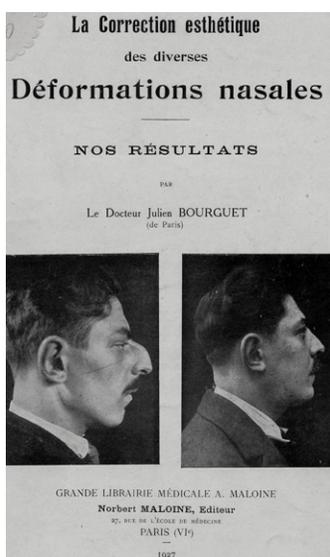


Figure 10: Title page of Bourguet's book on Rhinoplasty, issued in 1927 (see ref. No.12)

Conclusion

We conclude our review of the most significant achievements and textbooks/publications of the pioneering epoch of rhinoplasty. For space limitations, it is beyond the scope of this present historical contribution to quote all of them. Those interested in more complete information regarding the origin of rhinoplasty are kindly invited to refer to the comprehensive and detailed paper by McDowell et al, that includes more than 800 references²⁰.

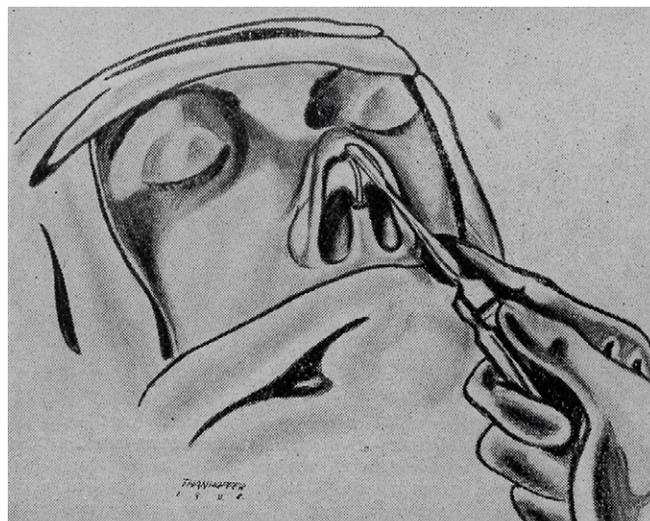


Figure 11: The transcollellar incision, described by A. Rethi (see ref. No. 18)

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RHINOPLASTY

GLOBAL PERSPECTIVES

RHINOPLASTY: ALL ABOUT PROPORTIONS AND AESTHETIC INSIGHT



STEFANO BRUSCHI
ITALY

Rhinoplasty is one of the most rewarding operations in aesthetic plastic surgery because it is an operation that, when done well, will last for a patient's lifetime. The nose is one of the first things people notice in the face, especially when its aesthetic appearance is not optimal; on the other hand, when you have a good-looking nose, it tends not to stand out. In fact, when meeting an attractive person, you don't say "what a beautiful nose," but rather "what a beautiful person." So when performing a rhinoplasty, you should not personalize the nose. Instead, you should adapt it to aesthetic standards in order to achieve the optimal aesthetic nose.

To proceed with a rhinoplasty for an aesthetically-pleasing nose, you must concentrate on and imitate optimal proportions that are synonymous with beauty. During a clinical evaluation, a surgeon checks the following areas:

- The nasal slope (nasofacial angle)
- Tip projection
- Nose length
- The nasolabial angle

The key point for optimal proportions is the dorsal slope, which is the visual transfer of the nasofacial angle. Only when the nasofacial angle is set to 30-35 degrees will you get the optimal proportion (**Figures 1, 2**).

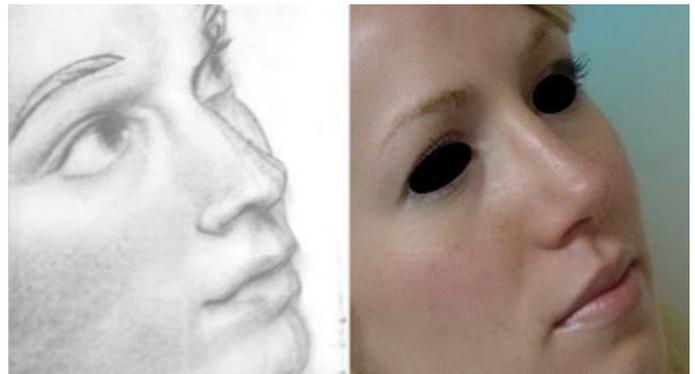


Figure 1.

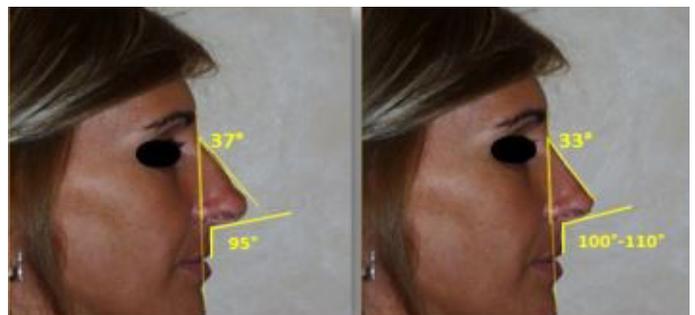


Figure 2.

How do we achieve optimal proportions during a rhinoplasty? Proportions can be done empirically during the surgical procedure. They rely upon the surgeon's insight and experience.

In closed rhinoplasty, you can gradually evaluate the intraoperative proportion due to the integrity of the cutaneous drape (Figures 3,4).



Figures 3,4.

On the other hand, in open rhinoplasty you can evaluate the proportions intraoperatively with measurements of the cartilaginous structures.

First, obtain the correct nasofacial angle of (30-35 degrees) by adjusting both the height of the septum from the nasal spine to the anterior septal angle to 19-21mm (Figure 5) and the height of the dome-defining point over the anterior septal angle to 5-6mm (Figure 6).

By adding together the first measurement (from the nasal spine to the anterior septal angle) and the second (from the anterior septal angle to the dome-defining point), you will get the optimal dorsal slope. The length of the nose from the nasion to the anterior septal angle can be 4.5-5cm (Figure 7).

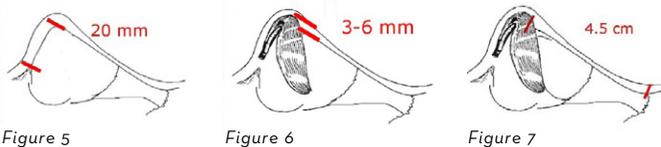


Figure 5

Figure 6

Figure 7

The application of the above measurements can also be seen in Figure 8.



Figure 8.

Intraoperative measurements will help you achieve optimal rhinoplasty proportions, but this is only the “hardware.” The “software” is your aesthetic insight, which is required to create a harmonious nose. Harmony is represented by curves of the nose (Figure 9).

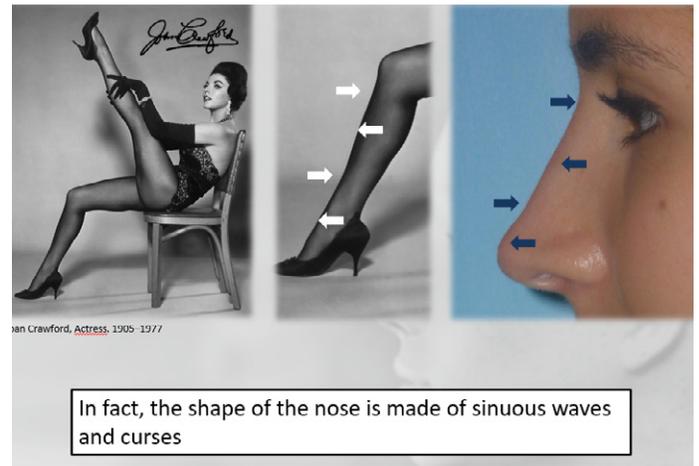


Figure 9.

According to these principles, after a rhinoplasty procedure you will not notice the nose anymore, but instead you will enhance the beauty of the entire face (Figure 10).



Figure 10: Optimal rhinoplasty in male to female. From left to right: pre-op, 6 months post-op, and after feminization, 4 years later.

In conclusion, you must consider proportions as well as your aesthetic insight in order to create an optimal nose. Today we have an infinite number of rhinoplasty procedures, but before choosing among them, you should identify the optimal aesthetic outcome that you want to achieve. Only after these evaluations can you implement your technical know-how. The concept of “ITPAS” (Figure 11) sums it all up.



Figure 11.



SERGIO CAPURRO
ITALY



MAURO PAGANO
ITALY

ELASTIC RHINOPLASTY

INTRODUCTION

A long nose can be shortened, and the tip reshaped, by implanting an elastic thread through a 2mm incision with a microsurgery scalpel. Elastic lifting of the nose has not only an aesthetic objective, but also a functional purpose. Indeed, by correcting the nasolabial angle, this procedure improves the patient's breathing.

PROCEDURE

The preoperative design is drawn along the sides of the nose, between the curved surface of the bridge of the nose and the plane surface of the ascending processes of the maxilla. The line continues along the nose-tip, passing halfway between the upper extremity of the nostrils and the apex of the tip of the nose. The design is completed by marking the inferior margins of the ascending processes of the maxilla, which delimit the safest area of intervention. An anti-staphylococcal antibiotic ointment is then applied inside the nostrils and a local anaesthetic (2% mepivacaine with epinephrine) is injected along the pathway of the elastic threads.

An incision is then made at the point where the nasal bones meet the frontal bone. A fine Klemmer is used to create a deep cavity to house the knot and an elastic thread mounted on a Jano needle (EP4 Elasticum, Korpo) is used. The two-tipped Jano needle is slightly curved. The tip of the needle is inserted into the small incision and anchors the elastic thread to the deep tissues of the procerus muscle. The needle partially emerges along the horizontal line of the design and the elastic thread is pulled through. As always, a Klemmer is fixed to the end of the thread.

The needle is extracted until 5mm of the posterior tip remain in the tissues. It is then rotated and continues along its pathway, partially emerging on the line of the inferior margin of the ascending process of the maxilla. The elastic thread is pulled through. The needle is extracted until 5mm of the tip remain in the tissues. It then rotates in the direction of the design. This is the point of passage from the bony portion of the nose to the cartilaginous portion. Along the anterior pathway between the two ascending processes of the maxilla, there is no longer

a bony plane that can prevent the needle from accidentally piercing the nasal cavities. To facilitate the passage of the needle between the skin and the cartilages, the assistant uses a 2.5ml syringe to inject a solution of local anesthetic directly beneath the skin. This increases the distance between the skin and the underlying cartilaginous structures and enables the two-tipped needle to pass through safely.

Once in proximity to the entry incision, the needle partially emerges. The elastic thread is pulled through and placed under tension. When 5mm of the posterior tip remain in the tissues, the needle anchors the thread to the deep tissues of the procerus and exits through the small incision (**Figure 1**). The two ends of the elastic thread are placed under tension and are knotted under the guidance of a Klemmer.

The suspension of the nose tip must be over-corrected. It is important to keep in mind that there may be as much as

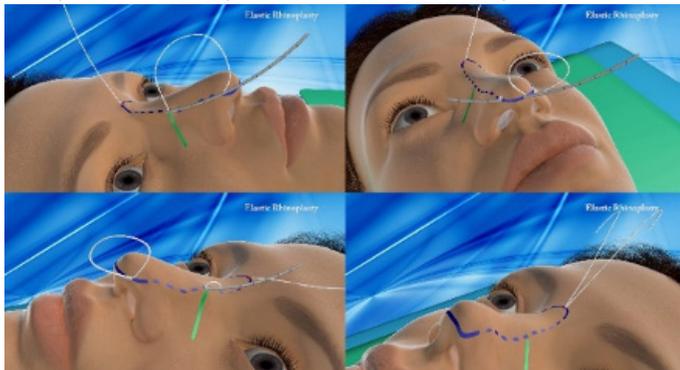


Figure 1: The elastic thread and the Jano needle are used to shorten the nose, lift the tip and correct the nasolabial angle through an incision of a few millimeters in the region of the procerus.

7ml of anesthetic in the nose. When the anesthesia and the edema subside, the tip of the nose will descend by a few millimeters. Before suturing the 2mm incision, we often insert a hemostatic sponge into the cavity; this serves to maintain the knot in depth. Post-operative pain is negligible.

Every day, the patient should apply an anti-staphylococcus ointment and a small sticking-plaster to the sutured incision. In the first few days, the ointment should also be applied to the nostrils. A “sling” sticking-plaster to support the nose-tip and a few plasters on the bridge of the nose complete the medication. The dressing should be replaced every day. In the following weeks, the nose must be washed thoroughly inside and out. It must be remembered that the nasal region is not clean, and that 30% of patients are carriers of staphylococcus. Therefore, a suitable antibiotic treatment must be started three days before the procedure and continued for 10 days

afterwards. An anti-staphylococcal ointment must be applied inside the nostrils and along the pathway of the thread for a few weeks.

DISCUSSION

Elastic rhinoplasty can be performed on noses that have a mobile tip. Noses with very evident bony defects are not suited to this procedure; in such cases, we carry out traditional rhinoplasty. Pre-existing alterations of the bridge of the nose are normally attenuated after elastic suspension and can be corrected by means of adipo-filling or filler. Once the nose has been shortened and the tip has been reduced, the inferior portion of the septum can be modified, in the same procedure, if necessary. Elastic lifting of the nose can improve the appearance of a high percentage of noses that are deemed to be too long. This economical mini-invasive procedure makes normal noses look cute. The elastic thread is transformed into a ligament and the result is stabilized.

CONCLUSION

This elastic plastic surgery procedure enables us to shorten the nose, lift the tip and correct the nasolabial angle simply, quickly and economically in a high percentage of patients. Even noses that have already been operated on several times can benefit from elastic rhinoplasty.



Figure 2: Elastic rhinoplasty. The elastic thread is implanted halfway between the apex of the nostrils and the extremity of the nose-tip. If it is implanted in a higher position, as in this patient, it can turn the tip of the nose upward. To facilitate this upward rotation a triangle of cartilage can be removed from the antero-superior portion of the septum.



Figure 3: Noses that have already been operated on several times can be shortened. Adipofilling can regularize the bridge of the nose and correct defects of shape. The patient can now breathe more easily.

TEN ESSENTIAL STEPS TO DEMYSTIFYING PRIMARY RHINOPLASTY



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Rhinoplasty is a difficult operation to perform consistently, let alone teach. The internal anatomy of the nose is variable and there are multiple maneuvers that can be used to achieve a similar external result. Rhinoplasty surgeons tend to be dogmatic in their thinking and approach as they have achieved consistent results in their hands by doing the same things repeatedly. In this article, the authors present their ten steps to primary non-traumatic rhinoplasty and their hybrid open/closed approach based on more than 1,500 consecutive rhinoplasties. We recognize that these ten steps will not encompass every rhinoplasty and there may always be a need for additional techniques; however, we feel that most primary noses can be performed on in this manner.

- 1. Skeletonize the nose via bilateral intercartilaginous incisions. Complete a full transfixion incision with a button knife through the membranous septum.** This allows for access to the dorsum from both the left and right nares and will allow for delivery of the lower lateral cartilages after the marginal incision.
- 2. Elevate nasal bone periosteum and depressor muscles.** Using a Joseph periosteal elevator, the periosteum of

the nasal bones is elevated to allow for dorsal reduction of the bones in a subperiosteal plane. If the depressor septi nasi is overactive, resulting in a plunging nasal tip, it is also swept off the maxilla with elevator.

- 3. Detach upper lateral cartilage from septum with a #11 blade.** The nasal skin is retracted using an Aufricht retractor and the 11 blade is swept superiorly. Separating the upper lateral cartilages from the septum is an important step that allows for controlled component reduction of the dorsum later on as well as making space for potential spreader grafts. This contrasts with a submucosal separation of septum and upper lateral cartilage.
- 4. Algorithmic tip surgery via tip eversion.** This step is achieved through several maneuvers after delivery of the lower lateral cartilages through marginal incision (*Figure 1*):
 - Conservative cephalic trim leaving approximately 4-6 mm of lower lateral cartilage behind.
 - Cartilage shaping sutures to shape the domes via interdomal or intradomal sutures.
 - Columellar strut secured by intracurral sutures.



Figure 1: The lower lateral cartilages are delivered in the hybrid open-closed approach.

- Tip graft, stacked and secured by Dermabond, avoids suture and manipulation of flimsy tip graft cartilage.
 - Adjustment of the lateral crura: if there is too much notching or weakness, it may require a mattress suture (Gruber), strut graft (Gunter), or an alar rim contour graft (Rohrich).
5. **Adjust medial footplates.** If the columella continues to hang, the medial crura need to be trimmed. We most commonly treat an over-projected tip by removing a wedge of medial crura.
 6. **Dorsal component surgery (reduction or augmentation).** Because all the components of the dorsum have been previously separated, each portion (septum, bone, upper lateral cartilage) can be reduced individually and control is achieved through careful reduction of bone with bony rasp and graded resection of cartilage with sharp Foman scissors.

7. **Non-tip cartilage grafts as indicated.** Need for spreader grafts for correction of dorsal aesthetic lines or breathing is evaluated. At this point miscellaneous crushed grafts can also be inserted to fill any irregularities in the dorsum.
8. **Caudal septal modification.** The nose can be shortened by a resection of caudal two-thirds of the septum and the tip may be rotated by an angled resection of the caudal septum. The caudal septum needs to be shortened to decrease columellar show or increase tip rotation. If additional stability is needed in the tip, septal extension graft is an option.
9. **Lateral low to low osteotomies/medial oblique.** A lateral controlled cortical osteotomy and in-fracture is performed to narrow the upper third. Keeping the osteotomy low-to-low prevents a palpable bony step-off from maxilla to nasal bone. A medial osteotomy and percutaneous osteotomies are done as indicated to allow for in-fracture.
10. **Alar base resection/alar rim excision.** After everything else is performed and the incisions are closed, the necessity for alar base resection is evaluated. Additionally, if the rim is thick, it can be debulked from the alar base resection incision.

There are advantages and disadvantages to both the open and closed rhinoplasty approach. We feel that this hybrid “open-closed” approach offers adequate exposure, reduces tip swelling by not opening the nose, and removes concern of being able to close over an elevated tip. With these ten essential steps, we feel that the majority of noses can be treated effectively and hope to make the procedure teachable and reproducible with reliable outcomes.



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REFINEMENT OF BASE ALAR WITH THE USE OF PUNCH: PERSONAL TECHNIQUE

SUMMARY

The following work presents a technique for refining the wing base using punch, a procedure that I have been carrying out since 2018 and which was published in *Advances in Plastic & Reconstructive Surgery*¹. This technique is performed on its own or as a complement to a rhinoplasty procedure or a rhino-modulation procedure with thread².

KEY WORDS

- Wing base
- Punch

INTRODUCTION

Regarding the narrowing of the alar base, there are different techniques that can be used in specific cases. Some of these techniques are described in chapter 9 of “Rhinoplasty” by Ortiz Monasterio³.

INDICATIONS

- Wide wing base

MATERIAL AND METHOD

- Punch 3, 3.5, 4 or 5mm
- PDS 4-0
- Local anesthesia with 2% xylocaine with epinephrine

SURGICAL TECHNIQUE

Local anesthesia consisting of 2% xylocaine with epinephrine is used in all cases. Using a 30g needle, the anesthesia is inserted into the periphery of the area where the wing tissue will be resected along with the punch. Depending on the punch used (3, 3.5, 4 or 5mm), it is possible to obtain a compact 8mm deep tissue cylinder of variable diameter without touching the nasal vestibule or the skin of the alar

margin. This prevents wound dehiscence and ensures minimal scarring and symmetrical alar margins (**Figure 1**).

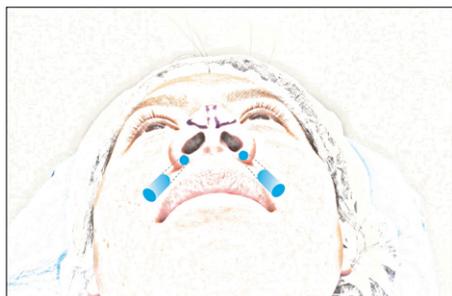


Figure 1.

Once the dermo-fat cylinders, which can be used to augment the previously de-epidermalised radix, are extracted, closure of the wound is performed. Closure can be done with a single stitch with 5-0 nylon, which can be removed after 72 hours. Alternatively, on a transfixing point of the alar base with PDS 3-0 or 4-0, you can make two punctate incisions with blade No. 11 in the wing margin. Next, using a straight needle loaded with PDS, a transfixing stitch is made by closing the spaces created by the punch. If necessary, additional individual stitches can be made on each wing edge, without tension, using 5-Onylon.

This technique can be performed as a unique look, or a complement to a rhinoplasty procedure, or with a rhinomodulation procedure with thread. When the alar rim conceals the columella, the resection with punch of the alar base can be combined with elliptical resection of the alar rim, as suggested by Millard ⁴.

CONCLUSION

- Symmetric resection of the alar base
- Prevention of dehiscence
- Minimal scarring
- Simple technique with a low learning curve



Figure 3: Rhinoplasty patient pre-operation, using a 4mm punch.



Figure 4: Rhinoplasty patient immediately post-operation.



Figure 5: Rhinoplasty patient five days post-operation.



Figure 2: Patient pre-operation, using a 3mm punch. Next, patient immediately post-operation. Finally, patient five days after the operation.

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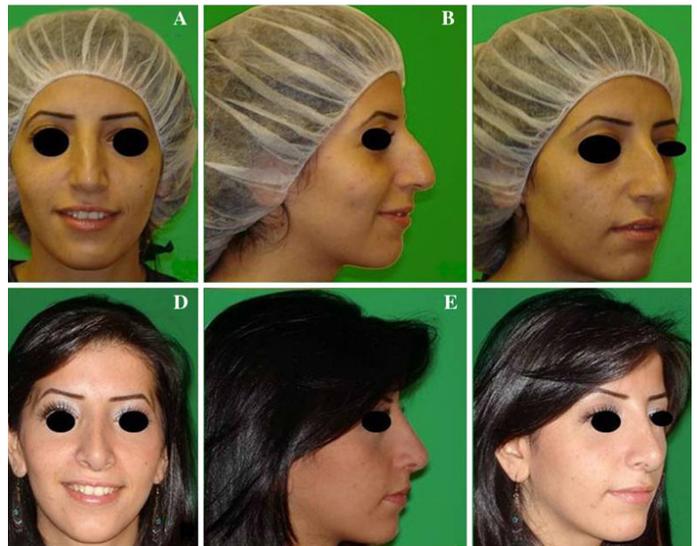
OPEN STRUCTURE RHINOPLASTY OF LONG NOSE



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The long nose represents one of the most undesirable features disturbing the harmony of the face. Frequently, it is the only complaint a patient has when requesting a rhinoplasty. Although it is common, a review of the surgical literature shows that little attention has been given to the evaluation and management of the long nose when compared to the number of publications on short nose. Direct and indirect anatomical factors contribute to the appearance of a long nose.

A long nose may result from elongation of the structures forming the long axis of the nose, particularly, a long nasal septum that invades the lip and pushes the nasal tip downward. Arregui and colleagues as well as Benlier and colleagues described the plunging nasal tip and the factors which ultimately contribute to the pathology of long nose in 2000 and 2006, respectively. Going further back, Guyuron described the dynamics of the nose before and after rhinoplasty in 1991. He emphasized that alteration in one zone of the nose may induce change in another zone. For example, individuals who have shallow or absent radix appear to have a long nose, because the nose is seen as ending at the medial eyebrows rather than at the radix (Figures 1a - 1f).



Figures 1a, 1b, 1c: The preoperative front, lateral, and oblique views of a 26-year-old female patient. She had a long nose with plunging tip, dorsal hump, and wide dorsum.

Figures 1d, 1e, 1f: The front, lateral, and oblique views one-year post-operation.

Johnson and colleagues are acknowledged for their introduction of the concept of “structure rhinoplasty” in 1990, which was later adopted by others. Open structure rhinoplasty is well

suited and ideal for Middle Eastern patients with ill-defined tips and weak lateral crurae relative to the thick skin enveloping the nose. Structure and strengthening of the cartilaginous framework are important to overcome the non-contractile thick skin and soft tissue. In long noses, the dorsal hump often presents concomitantly with plunging tips, but if we support the tip, the apparent height of the dorsum diminishes and the amount needed to be resected from the hump is decreased. This creates the illusion of reduction while preserving skeletal support. Structure of the plunging nasal tips commonly associated with long noses by different maneuvers including tip definition, support, grafting, and suture techniques does not only strengthen the tip but also rotates the tip up and shortens the nose (Figures 2a-2f).

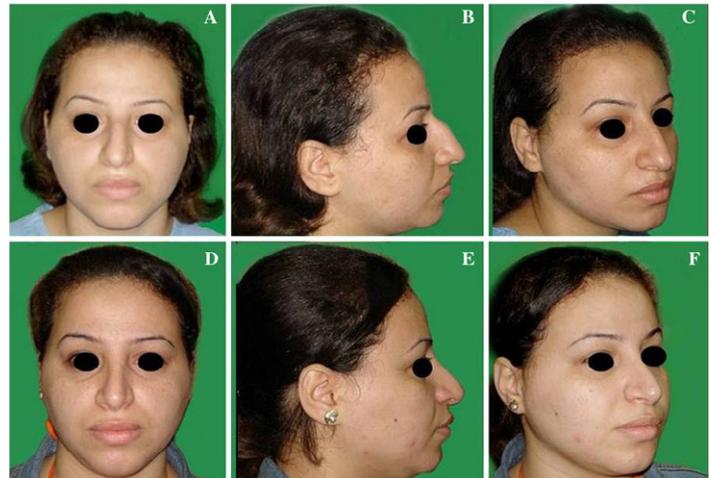


Figures 2a, 2b, 2c: The preoperative front, lateral, and oblique views of a 31-year-old male patient. He had a long nose with plunging tip and dorsal hump.

Figures 2d, 2e, 2f: The front, lateral, and oblique views one-year post-operation.

The long cartilaginous septum is always a direct underlying pathology of long nose; therefore, the excision of the caudal septum is a way to shorten the nose that also allows for upward rotation of the tip. Following hump removal, osteotomy is performed to close the open roof. When the hump is removed,

the dorsal projection is lowered which will result in a nose that appears wider and shorter. Osteotomies performed after hump removal can further narrow an already attenuated airway and create significant airway obstruction. Therefore, spreader grafts are used mainly to avoid any functional compromise which may occur a long time after the rhinoplasty procedure. Burring down the height and over-projecting radix is done when indicated in order to maintain the balance between dorsal height and radix. If needed, alar base reduction can be used to decrease the height of the tip (Figures 3a - 3f).



Figures 3a, 3b, 3c: The preoperative front, lateral, and oblique views of a 28-year-old female patient. She had a long nose with plunging tip and profound dorsal hump.

Figures 3d, 3e, 3f: The front, lateral, and oblique views one-year post-operation.

In conclusion, structure rhinoplasty is a concept that manipulates the nasal osseocartilaginous framework, alar cartilage, skin and soft tissue in the three-dimensional anatomy of the nose in order to achieve a pleasing nose with facial balance. The philosophy of open structure rhinoplasty focuses on maintaining and restoring the strength and support of the nasal skeleton while altering the contour to achieve the desired aesthetic result. When implementing structure rhinoplasty on long noses, reduction of the enlarged nasal structures while adding supporting cartilage grafts and sutures is required to build up a balanced nose.



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DROOPY TIP: A TAILORED APPROACH TO CORRECTION

Features of a droopy tip include inferior rotation of the tip and an acute nasolabial angle. Droopy tips can result from intrinsic or extrinsic factors or a combination thereof. The intrinsic factors are a long, lateral crus, a cephalic orientation of the lateral crus, or a weak, medial crus. The extrinsic factors responsible for droopy tips are tension nose (oversized septal cartilage), long upper lateral cartilage, or a weak tip or thick tip skin being pulled down by gravity.

The choice of surgical technique for the correction of a droopy tip depends on its etiology.

Lateral crural steal, lateral crural overlay and tongue-in-groove techniques are useful when a droopy tip is due to an intrinsic factor. Similarly, resection of oversized septum, long upper lateral cartilage and strengthening of the medial crura by columellar strut may be chosen depending on the extrinsic factor that is responsible for the droopy tip. Certain ancillary measures are also taken to aid the superior rotation of tip. Keeping in mind the tripod analogy, the medial crus fixation suture is used along with an interdomal stitch to allow the

paired lower lateral cartilage to rotate in unison. Cephalic trim of lateral crus and/or excision of the scroll area may be required to create the space for superior rotation of tip.

Lateral crural steal pulls the medial part of lateral crus into the middle crus by means of horizontal mattress suture. This, in addition to rotating the tip, also increases its projection. Lateral crural steal is indicated in droopy tips due to weak medial crura, evident by its buckled appearance (*Figures 1a, 1b*).



Figures 1a, 1b: Droopy tip due to short and weak medial crus. Lateral crural steal was carried out along with septoplasty, infracture, spreader flap, radix graft, tip plasty and columellar strut.

Lateral crural overlay entails transaction of its central part, followed by double breasting of the lateral and medial half, which is secured with a 5-0 nylon suture. This, in addition to rotating the tip, also decreases its projection. Lateral crural overlay is useful in droopy tips due to long lateral crura (**Figures 2a, 2b**).



Figures 2a, 2b: Long lateral crura are the primary cause of droopy tip. Along with lateral crural overlay, bony and cartilaginous hump excision, infracture, spreader graft, medial crural fixation suture and transdomal and intradomal suture were carried out.

Tongue-in-groove technique involves pushing the paired medial crura (the space between the medial crura being the groove) superiorly and securing it to the caudal part of the septum with a 5-0 nylon mattress suture. This technique is indicated when the superior rotation of the droopy tip is required without change in tip projection.

The open rhinoplasty approach is preferred as it allows excellent delineation of the cartilaginous framework. If present, the extraneous factors are first dealt with. For instance, in tension noses the septal cartilage is oversized in comparison to the bony component. This will result in the dorsal hump and the caudal septum pushing the nose down and into the lip. After the septal cartilage is released from its attachment, the dorsal and caudal strut are trimmed which allows the tip to rotate superiorly (**Figures 3a, 3b**).



Figures 3a, 3b: Cleft lip nose deformity with droopy tip due to oversized cartilaginous septum and lack of medial crural support. Humpectomy, caudal septal shortening with septoplasty, columellar strut and left lateral crural strut graft with reorientation of horizontal lateral crus were also done.

In another patient, the caudal septum was elongated and deviated to the right causing a droopy tip (**Figures 4a, 4b**).



Figures 4a, 4b: In this patient the caudal septum was jutting out and to the right, causing drooping and asymmetry of nasal tip. Caudal septal shortening with septoplasty along with scoring of dorsal strut and bilateral spreader graft, cephalic trim, medial crural fixation and inter- and intradomal suture were carried out.

Sometimes a combination of factors may be responsible for droopy tip (**Figures 5a, 5b**).



Figures 5a, 5b: Here the droopy tip was caused by a long right lateral crura and long right upper lateral cartilage. Horizontal orientation of the right lateral crura accounted for the tip symmetry along with lack of alar groove.

In droopy tips, accurate delineation of anatomical causes helps plan a tailored surgical approach. This along with understanding the nuances of interplay of forces affecting the nasal tip appearance ensures a successful outcome.

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HOW TO CORRECT ALAR RETRACTION IN ADULT CLEFT PATIENTS



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INTRODUCTION

Alar retraction is a typical stigma of cleft nose deformity, and lateral crura cephalic displacement is observed in most bilateral CLP patients. The tip is under-projected because of short medial crura, and the alar flare is increased due to longer, flattened lateral crura. Prior history of rhinoplasty could exacerbate the problem if an over-resection of the lateral crura is performed. In addition to an unfavourable aesthetic appearance, alar retraction may also result in the collapse of the external nasal valve with significant functional consequences. According to the Gunter classification of alar-columellar discrepancies, alar retraction is diagnosed by drawing a line from the anterior to the posterior apex of the nostril and a second line perpendicular to this. The ideal level of alar rim position should be 1-2mm above the anterior-to-posterior apex line. When the distance between the alar rim and the long axis of the nostril is greater than 2mm, the alar rim is cephalically retracted, exposing the nostril and creating an unnatural shape.

SURGICAL TECHNIQUE

In adult cleft patients, an over-resected or weak nasal tip framework is common; tip projection is usually lost, and the alar cartilage is deformed due to a short, medial crus. We advocate using the external rhinoplasty approach to correct alar retraction by strengthening and immobilizing the central tip complex using a septal extension graft. It is not rare to find a resected or deviated caudal septum; therefore, a reconstruction of the L-strut is the first goal to achieve. A septal extension graft allows the surgeon to achieve the desired tip projection and to fix the lower lateral cartilages in the right position with the tongue-in-groove technique. A long-term result is also guaranteed.

When the lower lateral cartilages are cephalically retracted, a caudal repositioning of the lateral crura is performed to bring the cartilage to a more anatomic position (45° angle with the midline). Then, the lateral crura steal permits the elongation of the medial crura, and a lateral crural strut graft is placed concomitantly for structural support to the repositioned and shortened lateral crura. The lateral crura strut graft is the most effective method to support weak lateral crura, adding stability to the nostril rim and the external nasal valve. The graft's lateral end is placed in a pocket from the caudal to the accessory cartilages, and the lateral crura-alar ring is restored. Lateral crura releasing, repositioning and reinforcement is the first step to correct alar rim retraction (**Figures 1, 2**).

In these cases, if a mild internal lining deficiency is observed at the time of the closure, a mucous vestibular flap is advanced and rotated laterally from the nasal pavement achieving a tension-free suture. When a significant alar retraction (> 3mm) is observed, composite grafting to the nasal vestibule to lower the alar margin may be necessary. Composite grafts are harvested from the lateral concha and contain cartilage and overlying skin on one side only. The donor site is closed primarily. An incision is made in the nasal vestibule, 2mm behind and parallel to the alar rim. Sharp-tip scissors are used to create space for the graft to be inset by spreading perpendicular to the incision. With the skin side facing into the nasal vestibule, the graft is inset with interrupted 5-0 absorbable sutures (**Figures 3, 4**).

CONCLUSION

Alar retraction and internal lining deficiency are common and complex problems in cleft patients. Cephalically positioned and deformed lower lateral cartilages are usually the leading cause; iatrogenic damage of prior surgeries can aggravate the problem. Structurally supportive grafting, including composite grafts and alar strut grafts, together with vestibular flaps, are effective solutions that can methodically be applied to most of these patients.

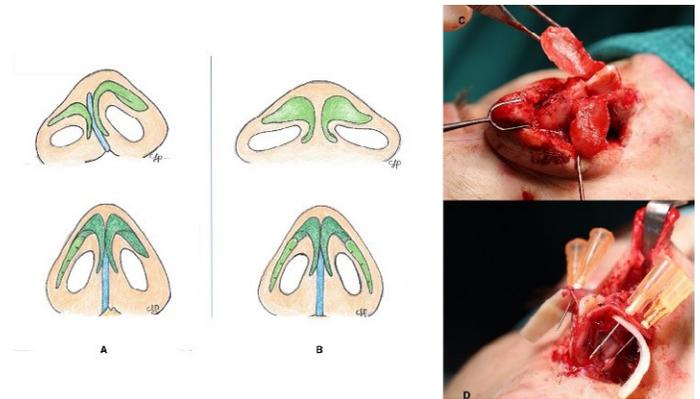


Figure 1: Repositioning and reinforcement of lower lateral cartilages in unilateral (A) and bilateral (B) clefts. Intraoperative photographs of the L-strut reconstruction with a septal extension graft; the lateral crura are released, repositioned and the new dome are marked for the lateral crura steal (C). Two lateral strut grafts are applied (D).



Figure 2: Pre-operative (A) and 18-month postoperative (B) views of a bilateral case of cleft lip and palate with mild alar retraction.

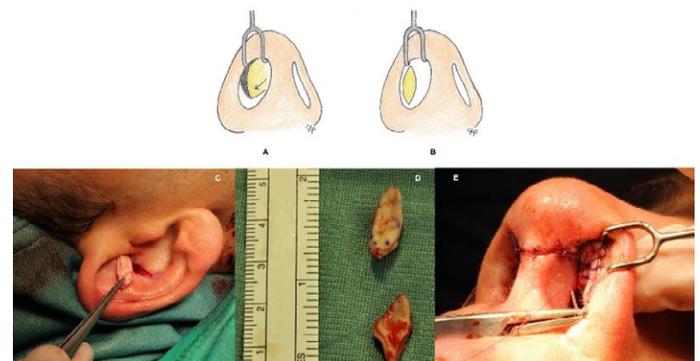


Figure 3: Correction of internal lining deficiency: vestibular flap (A), auricular composite graft (B). Intraoperative photographs of the composite grafts harvesting (C, D); composite grafts in place.



Figure 4: Preoperative (A) and immediate postoperative (B) views of a bilateral case of cleft lip and palate with severe alar retraction.

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THE USE OF HYALURONIC ACID (HA) FILLERS IN NON-SURGICAL RHINOPLASTY



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FEATURE SUMMARY

- Major structural changes of the nose are best achieved through surgical intervention.
- HA Fillers offer an alternative to augment areas or correct irregularities.
- Accurate placement of the filler is of paramount importance.
- Good option for patients who want to “wear” a rhinoplasty before committing to surgery or are not surgical candidates.
- Nasal anatomy knowledge is key to proper injection, specifically knowledge of the bony, cartilaginous and soft tissue framework.

FILLER SELECTION

- Hyaluronic acid (HA) fillers are employed.
- The longevity of HA fillers is greater for the nose compared to other areas of the face.
- Hyaluronidase can be used to remove the filler in cases of vascular compromise or superficial injection of the product.
- HA is easily molded to the desired contour. Post injection swelling has to be considered due to the filler hydrophilicity.

ANESTHESIA

- Topical anesthetics are used. The HA fillers available combine the HA with lidocaine.

Figure 1: Pre and 1-week post injection lateral view of a 30-year-old female who presented with a desire for correction of the appearance of her nose. HA filler was injected above and below the dorsal hump and at the level of the nasal tip.



Figure 2: Pre and immediate post injection lateral view of a 21-year-old female who presented with a desire for correction of the appearance of her nose. HA filler was injected above and below the dorsal hump.



TECHNIQUE

- Smaller needles are used to optimize control over the injection.
- Serial puncture, linear threading, fanning and crosshatching may be used.

NASAL DORSUM AND SIDEWALLS

- Small amounts of HA should be used.
- The skin is thinner and more mobile.
- The HA filler is layered from deep to superficial.
- To straighten a dorsal hump, the filler is injected both above and below.
- For a saddle nose deformity, injection is performed into the concavity, to bridge the nasal bones with the cartilaginous framework.

NASAL TIP AND ALA

- Small amounts of HA should be used.
- Constant assessment of skin perfusion should be performed.
- Filler depot injections can be performed to increase tip projection and improve rotation.

OUTCOMES

- Clinical examples of patients with HA filler injections for non-surgical rhinoplasty are shown (**Figures 1, 2**).



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INJECTION RHINOPLASTY: A PARADIGM SHIFT FROM SURGICAL TO NONSURGICAL

INTRODUCTION

The nose is the central part of the face and the most important aspect of one's beauty. Recently, there has been a paradigm shift from surgical to injection (liquid) rhinoplasty with the use of hyaluronic acid fillers. The latter method is preferred since it not only provides immediate results, but also because there is minimal to no downtime. However, nasal reshaping, whether surgically through rhinoplasty or non-surgically using soft tissue fillers, is always challenging. Currently, soft tissue fillers are ranked second-most popular amongst all minimally-invasive procedures worldwide, showing a clear paradigm shift. In this article we will discuss various areas of nasal aesthetic corrections.

PRE-PROCEDURE DETAILS

Detailed medical history should be taken from the patient, including history of trauma or possible previous rhinoplasty procedures. Facial documentation with photographs (of the front view, lateral views, and basal views) is mandatory to document the deformities and the intended sites of correction. It must be emphasized to patients that this procedure results in a temporary correction since hyaluronic acid degrades over time. After a time period of 45 minutes (after having applied

the local numbing cream), the area is cleaned and the injection sites are remarked. Nasal contouring can be done using cannula or with needles. To achieve the desired result, we have been using Juvederm Volift (from Allergan Inc.) hyaluronic acid fillers for nose reshaping due to less downtime, smoothness of the filler, less hydration and higher cohesivity.

PROCEDURE DETAILS

The patient is placed comfortably on a chair standing in an upright position with a back rest and injections are carried out at the intended sites.

Dorsum: 2-3 points are injected using a needle (after aspiration), supraperiosteal level, directly on the dorsum, with the needle directed at 45 degrees from the dorsum (**Figure 1**). We suggest injecting in small boluses only, injecting less than .02ml per site.

Immediately after injection, gentle molding is to be done. More filler can be added if required to get the desired result.



Figure 1

When using the cannula, we enter from the tip and inject microaliquots in retrograde direction.

Tip: Tip correction is desired primarily for lifting in the case of a parrot beak-shaped nose (drooping tip) or to give the nose more definition and contour in the case of a box nose shape. For tip correction, the needle is placed obliquely to the lip axis at a 45-degree angle and injected at intradermal or subdermal level.

Ala: Alar correction is intended to reshape the alar or to correct deformities like height differences between the individual ala. For alar correction, the needle is placed directly on the alar areas requiring correction with the needle directed at 45 degrees and injected at intradermal level.

PRACTICAL TIPS FOR SAFE INJECTION

- Ensure you have thorough anatomical knowledge of the plane of injection
- Ensure the patient can breathe properly
- Always use small boluses of <0.02ml
- Inject slowly
- If using cannula, inject in a retrograde direction using microaliquots only
- Do not over-correct

POST-PROCEDURE DETAILS

After the injections have been completed, patients are given a mirror for self-inspection followed by a close examination of the skin for any signs of blanching. Pre- and post-procedure images can be seen in **Figures 2a, 2b, 3a** and **3b**. Post-procedure instructions are explained to patient in detail with special instructions not to massage the injected nasal area for at least 3-4 days. A follow-up visit is scheduled for two weeks post-procedure. If required, any touch-up is done during the follow-up visit.

DISCUSSION

The nose is a danger zone because of the dense anastomotic network of vessels found there. Nasal fillers are an effective treatment option for patients seeking nonsurgical rhinoplasty such as dorsal corrections as well as for post-surgical rhinoplasty patients who wish to correct residual deformities. However, a word of caution: thorough knowledge of the surgical anatomy of various vascular structures in and around the nose is of utmost importance before starting injection rhinoplasty. Anatomy can be altered when correcting traumatic deformities or performing

post-surgical rhinoplasty. Without adequate knowledge, more harm than help can easily be done to the patient.

Various complications have been documented in literature with the usage of nasal fillers, including vascular emboli and necrosis¹⁻³, vision loss⁴⁻⁵, ocular ischemia⁶, the Tyndall effect⁷ and infection. Vision loss or blindness is the most dangerous of these complications, due to the eye's proximity to the neurovascular arcade.

CONCLUSION

Hyaluronic acid fillers are an excellent choice for nonsurgical nasal reshaping. The procedure is quick and requires almost no downtime. At the same time, over-aggressive treatment should be avoided due to the risks involved, including blindness. The author suggests that only highly skilled specialists that are certified plastic surgeons perform nasal injections in order to minimize the risks and give a smooth and pleasing result.



Figure 2a: Patient pre-procedure.



Figure 2b: Patient post-procedure.



Figure 3a: Patient pre-procedure.



Figure 3b: Patient post-procedure.

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TREATMENT OF NOSE VALVE DEFORMITIES WITH THREAD METHODS



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INTRODUCTION

Increasingly, patients are seeking medical assistance to deal with complaints about nasal breathing disorders which have arisen from unsuccessful rhinoplasty. In such cases, difficulty in nasal breathing is most often caused by the nasal valve system dysfunction. In these instances, classical treatment methods require that a surgeon possesses a good knowledge of anatomy and a mastery of filigree surgery technique which does not always lead to satisfactory results^{1, 2, 3, 4}. In the past, thread suturing has been used for this purpose; however, the proposed methods provide short-term results due to the application of ordinary smooth suture material and not completely adequate suturing technique⁵.



Figure 1: Patient after unsuccessful rhinoplasty at the moment of air inhalation, showing weakness in the movable part of the nose's lateral wall.

MATERIAL AND METHODS

Anatomically, a distinction is made between the anterior and posterior nose valves. The following are considered to constitute the anterior valve boundary: columella, lateral crus of alar

cartilage and fundus of nasal vestibule. Anterior valve dysfunction is mainly caused by the weakness of triangular cartilage or the loss of its elasticity. Stabilization of its movable part is necessary for correcting this problem (Figure 1).

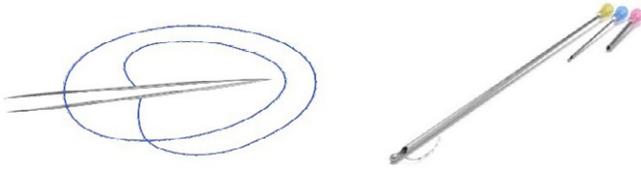


Figure 2: Patient after unsuccessful rhinoplasty. The presence of "sail" narrows the lumen of nasal passage.

On examination of the nostrils from the side, one can see the nose posterior valve which is delineated by the nose septum, the lower part of triangular cartilage and the anterior end of the inferior turbinate (Figure 2).

The main cause of nose posterior valve dysfunction is narrowness of the valve (less than 10-degree angle). It is necessary to widen this angle for treatment of the above-mentioned pathology.

We have elaborated the techniques for suturing the internal and external nasal valves using the special suture material, which contains double-edged needles and polypropylene threads with bidirectional cogs. It also contains threads with



Figures 3a, 3b: Suture thread products designed for correction of nose valve deformities: two double-edged needles with polypropylene suture thread and a cannula with absorbable suture thread pre-placed in it.

multi-directional cogs which are made of absorbable material and equipped with blunt-pointed cannulas (**Figures 3a, 3b**). The absorbable threads are composed of polylactic acid with caprolactone. The surgical suture material has a biodegradation period of 1.5-2 years^{6,7}.

SURGICAL TECHNIQUE

The procedures are performed without incisions, through punctures, under infiltration anesthesia.

The internal valve is sutured with a product consisting of two double-edged needles, the points of which, when juxtaposed, form one point; one 50cm-long thread is attached to them. The points of these needles are injected into the skin in the nose bridge area up to the periosteum, where they are separated. One of the needles initially advances subcutaneously and subsequently under the mucous membrane to the corner of internal valve on the right and is punctured into the nasal lumen. Here the needle is not fully withdrawn: the point is left in the submucosal space and turned around. Next, the hook maneuver is performed, the small piece of tissue is picked up, and the second point returns back to the nasion area. Pricking, incomplete withdrawal of the needle from under the skin, maximum pull-

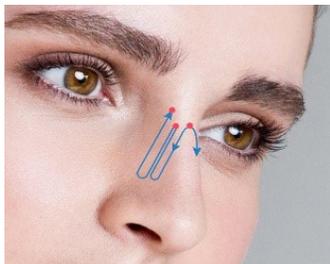


Figure 4: Scheme of placing the suture thread for correcting the deformation of internal valve.

up of the thread, the hook maneuver, engagement of the periosteum and returning of the needle with the first point towards the valve are also performed here. These steps are carried out 2-3 times until the valve angle has been sufficiently increased and the valve has been opened. While still on the operating table, the patient should already be able to note the significant improvement in breathing through the right nostril. The same maneuvers are then performed on the left nostril (**Figure 4**).

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Figure 5: Placing the suture thread to correct the deformation of the external valve.



The procedures designed for the elimination of valvular deformity of the external valve are somewhat easier and less traumatic to perform, since only the strengthening of the weak lateral nose wall is carried out. At the same time, several threads with multidirectional cogs are positioned fanwise through the punctures in the region of the nasal vestibule through the entire nasal sidewall (**Figure 5**).

RESULTS

This article describes cases involving nasal valve system deformities occurring after unsuccessful rhinoplasty, which we treated using our thread correction methods. There was a total of 72 of these cases, the majority (68%) of which involved internal valve deformities. Among all 72 cases, 39 were characterized as bilateral deformities and 33 as unilateral deformities.

Applying the proposed technique, we managed to achieve the dilation of the nasal passage around the internal valve. In addition, given the weakness of the nasal sidewall, the strengthening technique proved to be effective. For both pathologies, free passage of air through the nasal passages was ensured in all cases and remained stable for many years. Disease relapses were not observed.

CONCLUSIONS

The proposed methods of minimally invasive interventions designed to eliminate deformities of the nasal valve system offer an opportunity to achieve positive long-term results. Provided that patients are correctly diagnosed and selected properly, these methods may serve as a solid base for a surgeon dealing with rhinology. The significance of these procedures lies in the fact that they represent one of the few alternatives to traditional surgical rhinology that may be performed quickly (in 10-30 minutes), in the outpatient setting, under infiltration anesthesia and with a short rehabilitation period (2-5 days).



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THE IMPORTANCE OF SKIN MANAGEMENT IN ETHNIC NOSES

Ethnic noses are differentiated from Caucasian noses, but even within this distinction there are different racial subgroups that share common anatomical characteristics that need to be considered when creating a surgical plan. In this article, we are going to look at ethnic-Latin noses in particular and the need for proper skin management.

Ethnic-Latin noses are characterized by short and wide nasal bones, a short septum, poor tip support with weak alar cartilage, and hypertrophy of depressor muscles that generate a droopy tip. This tip feature results in a hyperdynamic nasal tip with poor projection and caudal rotation. This weak structure combined with the weight of thick (Latin) skin results in a nose without definition.

The great challenge is to achieve aesthetic definition of the nose without losing the harmony of Latin ethnic features. The surgical nose definition, especially at the break point, requires a prior tip skin treatment to help reach aesthetic success.

The skin thickness observed in these Latin noses is predominantly thicker at the tip, refined at the level of the columella and osseocartilaginous vault, and then thick again at the radix level. The thick skin has dilated pores, a prominent adnexal structure and large subcutaneous fibromuscular layer, and is prone to acne or rosacea.

The pre-surgical medical treatment for skin thickness is aimed to reduce the size of the sebaceous glands. An oral regimen

of isotretinoin tablets of 20mg is performed for one month, stopped one week before surgery and then resumed two weeks later. Isotretinoin refines the skin and helps reduce inflammation. Dermatological monitoring is important since liver enzymes must be measured monthly during treatment and all negative interactions of isotretinoin should be known, such as with the tetracyclines commonly used for the treatment of acne. It is important to advise women of childbearing age on the teratogenic complications of the drug and consequently the use of double contraception while the treatment lasts and after having finished it.



Figure 1.

The dissection of the thick skin area of the nasal tip is carried out in a double plane, initially supraSMAS dissection leaving the SMAS attached to the lower lateral cartilages, followed by a subSMAS dissection and resection of fibroadipose tissue from this area, especially in the supratip region, avoiding its extension towards the laterals or in the subdermal plane that can cause irrigation disorders (**Figure 1**).

Surgical treatment is performed using an open approach that allows better anatomical visualization to be able to carry out a restructuring with more stable results.

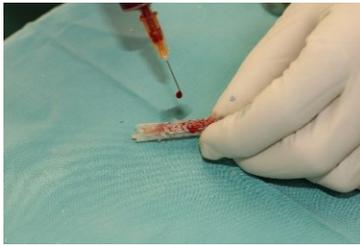


Figure 2.



Figures 3a, 2b.



Figure 4.

The restructuring treatment begins at the dorsum. In the case of an osseocartilaginous hump, it is resected through low to high lateral osteotomies and by restructuring with spreader graft or spreader flaps. In case dorsum augmentation is needed, autologous grafts are strongly preferred. If an increase of more than 4mm is needed, a rib graft is required (**Figures 2a, 2b**).

For the tip restructure, the lateral steel crura and turnover alar flap are used to flatten and strengthen the convex lateral crura, usually found in a bulbous tip. This is combined with a dome defining suture and alar spanning suture. If the tip needs to be raised, in the case of a droopy tip, a septal extension graft is placed. If the projection and rotation are adequate, a columellar strut is placed as a stabilizer. Alar strut grafts and alar rim grafts are usually used. After closing, the need for nasal base reduction is evaluated (**Figure 3**).

Splinting is performed, avoiding dead spaces that may evolve into unwanted scar tissue. During this process, silicone sheets are placed in the supratip region and the micropore and termomaleable splint are placed in the lateral alar zone (**Figure 4**).

Postsurgical care recommendations are sleeping with the head at a 45-degree angle to help lymphatic drainage and to reduce edema and using cold compresses constantly for 72 hours.

It is required to use nose-taping for 30-60 days following surgery as a nightly treatment. Additionally, in the case of excessive scarring, massage and infiltration with 0.05cc triamcinolone diluted with 2% subdermal lidocaine is recommended (**Figures 5a-5d, 6**).



Figures 5a, 5b.



Figures 5c, 5d.



Figure 6.

CONCLUSION

Ethnic-Latin rhinoplasties unfailingly require special skin management and meticulous planning prior to surgery. The use of cutaneous medical treatment is a fundamental tool to treat the obstacle of skin thickness and achieve a satisfactory aesthetic cosmetic result.

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A TWO-DAY VIRTUAL EVENT LIKE NO OTHER!

We are excited to bring you ISAPS WORLD: our „world-first“ non-stop 48-hour aesthetic conference. Our unique ISAPS WORLD will feature a state-of-the-art scientific program with top speakers, expert panels, hot topics and free communication papers, and take place continuously over two days. Our fully virtual program will be presented live and On Demand across all time zones, meaning you can tune in from your home, your office, or wherever you are, or even customize your own program to watch at any time!

Don't miss us: live from 3:00 UTC on March 27th to 23:00 UTC on March 28th!

