Letter to the Editor

External Rhinoplasty by Skin Excision to Correct Hypertrophic Tip of an Elderly Patient

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An elderly patient's aesthetic requirements to correct a large and drooping nasal tip are difficult to satisfy. When the skin is thick, hard and sebaceous, tip deformity cannot be corrected with a standard rhinoplasty procedure. The authors present a new two-step approach of hypertrophic tip correction combining skin excision, cartilaginous framework remodeling, dermabrasion, and the results for one patient after a two-year follow-up.

CASE REPORT AND SURGICAL TECHNIQUE

A 57-year-old man complained of a large and drooping tip that was worsening with age. Clinical examination noted sebaceous, hard, and poorly contractile skin.

Two atypical procedures were performed under local anesthesia. In the first step, a 4 mm wide cutaneous and subcutaneous flap was excised around the aesthetic subunit of the tip according to a pre-established U drawing. The alar cartilages were dissected under the flap. The cranial parts of the domus were resected and both intermediate crus were sutured together with two 5-0 polydioxanone (PDS,© Ethicon GmbH, Norderstedt, Germany) stitches to refine the cartilaginous tip. Two Burow triangles were excised from either side of the U-resection above the nasal wings. The skin was approximated subcutaneously with 5-0 polydioxanone (PDS©) sutures and closed with 6-0 polyamide monofilament (Flexocrin,© B. Braun, Melsungen, Germany) sutures. Nasal dressing was stopped on the seventh postoperative day along with dorsal sutures. Superficial dermis shaving was secondarily performed with a scalpel six months after the first procedure to refine the skin. Pretreatment, intraoperative, and postoperative photographs are shown in Figure 1.

The flap did not develop scar complications or "pin cushioning" during the healing process. An assessment consultation was performed two years after the final procedure by an independent surgeon who was not involved in the patient's care. The patient's satisfaction was assessed on a 1-5 scale, and the patient reported to the independent surgeon that his level of satisfaction was 5 of 5, the best possible.

DISCUSSION

Nasal plasty by external skin resection has existed as long as rhinoplasty and was reported by famous surgeons such as Joseph[1] or Gonzales-Ulloa[2] to correct extreme nose deformation. More recently, several authors have reported the performance of similar procedures with hidden scars.[3-5] However, their cutaneous resections were horizontal or vertical and only treated a single axis of the hypertrophy. The originality of the present technique is to correct both a droopy and a bulky tip with a U-drawing. This pre-established pattern, placed strictly on the border of the tip, wing, and soft triangle

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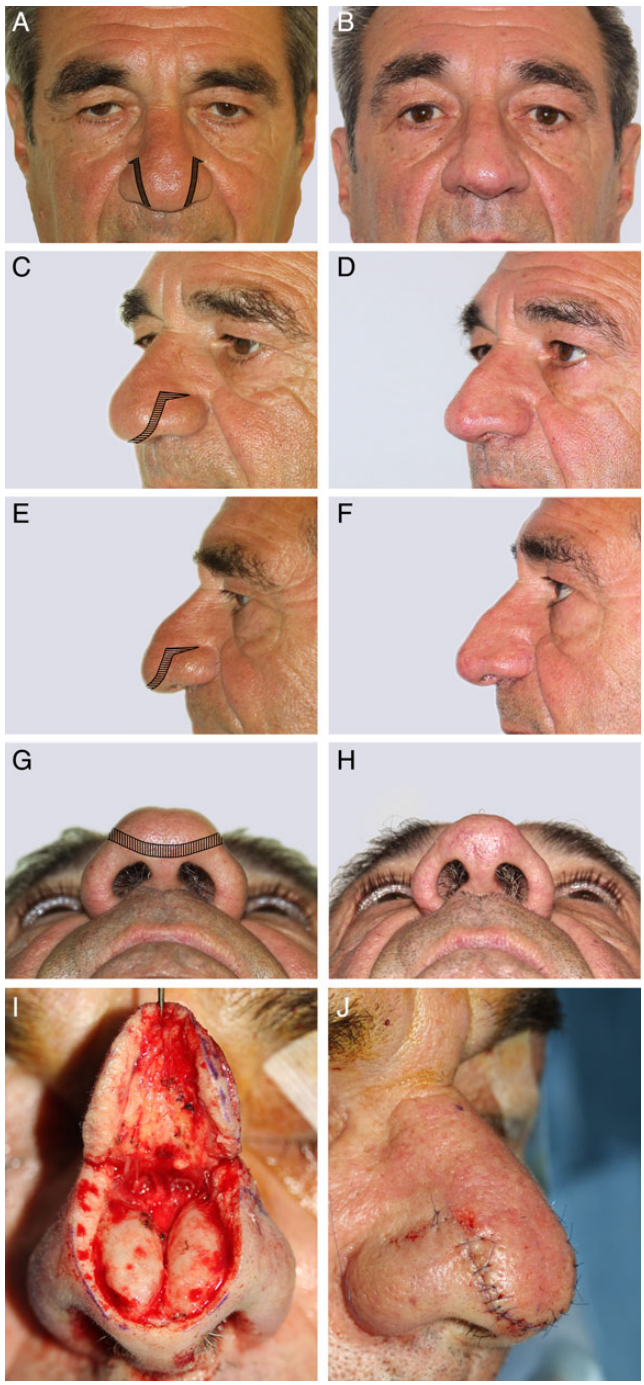

Figure 1. (A, C, E, G) Pretreatment U-drawing, on the border of tip, soft triangles, and alar subunits on the 57-year-old male patient. (B, D, F, H) Postoperative photographs obtained at two years. (I) Direct alar cartilage surgical approach by an atypical window. (J) Immediate postoperative photograph of the cutaneous sutures.

subunits made it possible to hide the scars. Secondary scalpel shaving enabled further reduction.

The patient was seen in our department after being rejected by many plastic surgeons. He was fully informed that the thickness and sebaceous aspect of the skin did not allow for hope of a good result with the usual rhinoplasty techniques. He understood and agreed to the exceptional aspect of this two-step procedure and the risk of apparent scars.

CONCLUSION

It is not possible to correct the wide, droopy, and sebaceous tip of elderly subjects without proposing skin resection.[4] We present an original two-step procedure that reduces the vertical and horizontal dimensions of the tip with a hidden scar around the aesthetic subunit of the tip. This is an atypical procedure that should only be performed in an aging patient who has no history of default healing (hypertophic or keloid scars) and has been fully informed about the scars. The good results obtained in the reported case need to be reproduced in a series and compared with the traditional open approach with manipulation of the underlying cartilage.

Disclosures

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