12 A 30 years Learning Experience

The most significant change in my understanding of the nasal anatomy relates to the elastic cuff. Initially I was setting the cuff back according to the calculated amount on the life-size profile photograph. Reviewing patients after one or more years and checking with the template showed a loss of tip projection when the dorsum had been reduced as in the case of a tension nose. Results improved when I avoided setting the elastic cuff posteriorly. Of course, that will not be the case for a non-tension nose that might have a projecting tip. Then the elastic cuff repositioning should follow the planned changes.

Septal surgery has been a difficult proposition for me. It was easy to fracture the thin septal cartilage just above the vomer and that leads to a swinging door situation. Centralising a deviated septal cartilage is then difficult due to the strength of the cartilage where it joins the perpendicular plate. Doing a chondrotomy along the line of cartilage to bone attachment resulted in a collapse of the septal cartilage. After that experience I devised the safe chondrotomy, so the mobilised cartilage has a cartilage projection to rest upon. To date, there have been no further septal collapses.

Recurrence of septal deviation is annoying to the patient and, of course, also to me. This has been largely prevented by retaining strong septal splints for at least two weeks. Previously, the external nasal and internal septal splints were removed at the appointment on the sixth or eighth post-operation day. The other procedure that has been helpful is using the upper lateral cartilages as stays. I have had to revise the results of other surgeons and in one such case there was an amazing amount of redundant upper lateral cartilage especially at the distal end. The cartilages were separated from the septum and pulled down whereupon they moved anteriorly about 5 or 6 mm. Trimming this redundancy and suturing the cartilages to the septum under tension vastly improved the shape of the nose and the airway was opened.

I will never understand why spreader grafts are placed all the way down the bridge line. There should be adequate width of the dorsum at the keystone area of the nose, but normal noses have a narrow distal bridge. The idea of opening the anterior portion of the internal nasal valve to correct an airway problem makes no sense to me. Surely air molecules are going to be sucked into the nose along the shortest and widest route, closer to the floor of the nose. Expired air may travel in a more forward pathway and exit via the anterior part of the internal nasal valve, but expiration is not the issue for patients with a blocked nose.

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