Invited Discussion on: Anterior Nasal Spine Relocation for Caudal Septal Deviation: A Case Series and Discussion of Common Scenarios

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The authors point out the importance of the anterior nasal spine (ANS) in correcting caudal septal deflections. I agree that this is an important point, which often is not recognized enough, and it is essential not only from a functional aspect but also, even more importantly, from an aesthetic point of view.

The article describes different scenarios, but as a key point in case of dislocation of the ANS, a gentle fracturing of the bony structure and a relocation is recommended. This is described as an easy and efficient technique. The caudal deviation of the nasal frame has been the subject of other articles as well because of its intricacy (Ref [1–4]).

The authors state that a dislocation of the ANS separating the septal cartilage from the spine would create instability. In my experience, a side-to-side fixation of the dislocated anterior septum to the displaced ANS gives a very stable and strong construction, especially with fixation of the septum transosseously, using a horizontal non-resorbable mattress suture. This is the only indication to use a non-resorbable Prolene^R suture in rhinoplasty, for me, because this suture is well covered with thick soft tissues and the chance of infection or extrusion is minimal (Ref [5]). In fact, in more than 40 years I have never seen any problems in using a non-resorbable suture (Fig. 1).

I believe that a transosseous fixation is essential. In a study of my own cases, 10% of the patients showed a dislocation after fixing the septum only to the soft tissue around the ANS.

If the ANS is very small and it is difficult to perforate the bone directly with a side-cutting burr, we use a 26-gauge needle and fix it to an adapter that we developed for the TTC-suture technique (Medicon^R) or just fix it to a cylindrical drill. By doing so, we can perforate even a very small ANS (Fig. 2).

Cutting a displaced spine and shifting it into the midline are needed in all cases of a severe dislocation, from our point of view also, which is the important message of this paper. In major dislocations of the ANS, a side-to-side fixation of the anterior septum will not be able to bring the anterior septal border in the midline, and in contrast to the authors, we do not believe that we will get a reliably stable result without any fixation. This is also demonstrated in the results as cited by the authors of the current article: In 17% of the patients, there was a residual deviation even though they osteotomized the ANS. We believe that a fixation by a microplate and microscrews is much more reliable. However, this is not a simple and quick procedure. Therefore, we follow the following algorithm: In minor dislocations, we prefer a side-to-side fixation with non-resorbable mattress sutures to the dislocated ANS, and in major dislocations, we osteotomize the ANS, shift it in the midline and fix it with a microplate (Fig. 3).

All these maneuvers are very delicate, and therefore, we agree with the authors' recommendation of an open approach for such cases.

This paper contributes a great deal by emphasizing the importance of a successful septoplasty as a prerequisite for a successful rhinoplasty, and I would like to congratulate

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Fig. 1 Forty-yrs-old pat. after severe nasal trauma and consecutive repositioning, remaining septal deviation and dislocation of the ANS 10 mm to the left

Fig. 2 Septum was bended; ANS was dislocated. Straightening by scoring + spreader grafts for splinting, osteotomy of the ANS and fixation by microplate and microscrew

Fig. 3 Straightening by scoring and spreader grafts, relocation of the ANS and fixation by microplate and microscrew

Fig. 4 Relocation of the ANS and fixation of the shortened septum to the replaced and fixed ANS

the authors for their focus on the problem of ANS dislocation (Fig. 4).

It is important to aver that exact midline position of the anterior septum is even more important for a good aesthetic result than for a good function. We believe that a good long-term outcome needs a strong fixation of the osteotomized ANS, which is better achieved with a microplate.

Compliance with Ethical Standards

Conflict of interest The author declares that he has no conflicts of interest to disclose.

Ethical Approval This article does not contain any studies with human participants or animals performed by the author.

Informed Consent Informed consent is not required for this type of article.

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