The luxation (cartilage delivery) technique may be used to achieve a predictable, individualized result in nasal tip rhinoplasty. The author describes how this technique, using a bipedicle flap with an intercartilaginous and rim incision, allows superior visualization of the domal region without structural disruption of the cartilaginous arch. (Aesthetic Surg J 2001;21:345-348.)

Treatment of the nasal tip requires cartilage modification and reshaping through partial excision, transection, repositioning, suturing, or graft augmentation. Achieving or preserving adequate tip projection is one of the main goals in primary rhinoplasty. There are various endonasal techniques for exposure of the lower lateral cartilages, including the intercartilaginous retrograde technique (McIndoe); the transcortilaginous vestibular, infracartilaginous, and transcolumellar techniques (Rethi); and the extender exposure technique (Gillies and Potter). The closed techniques limit exposure of the lower lateral cartilages and dome.

The work of Rodolphe Meyer in Switzerland and the books and papers of Jack Sheen provided encouragement for me to begin using the luxation (cartilage delivery) technique to achieve a more predictable and symmetrical result in tip rhinoplasty. I now use this approach to rhinoplasty, which has evolved over a 10-year period, for 90% of my patients.

Tip anatomy has been exhaustively described by many authors, including Sheen and Daniel. In my view, the domal junction (the transition from the middle to lateral crus) is the key to aesthetic refinement of the tip. My approach is to widely expose the domal region with use of the cartilage delivery technique, without structural disruption of the cartilaginous arch. The procedure is performed with the use of local anesthesia, 2% lidocaine with 5 ug/mL epinephrine, and intravenous sedation.

Two parallel incisions are made in the vestibule, creating a bipedicle vestibular skin and cartilage flap: the first is the intercartilaginous incision, and the second runs along the caudal margin of the alar cartilage 2 mm from the rim, extending into the lateral third of the ala where the cartilage diverges from the alar rim (Figure 1). The lateral end of the incision may also turn away from the rim after this divergence.

An all too common complication of rhinoplasty is slight tip asymmetry. This may be caused by resection of both alar cartilages with the same curved right-handed scissors through a limited exposure. In certain cases, the combination of wide lateral crus and narrow dome may lead to unintentional division, weakening, or resection of the domes. Another disadvantage of the classical intercartilaginous or transcortilaginous approach is the inability to visualize the relation between the upper lateral cartilage and the lateral crus.

Exposing the alar cartilages provides a clear view of tip anatomy and facilitates performance of precise, symmetric resections. The direct visualization of Sheen’s angle of divergence and rotation reduces the risk of making imprecise resections. Augmentation tip grafting can be easily done with the graft placed in the correct position and fixed according to the surgeon’s preference.

We achieved excellent results in 95% of the patients who underwent this technique (Figure 3), and there were no serious complications. In one patient, a retracted scar of the rim incision at the Converse soft triangle was seen; the problem was corrected with a small cartilage graft.
Figure 1. Rim incision running the caudal margin of the alar cartilage.

Figure 2. Transfixion maneuver and delivery flap (intraoperative photo and illustration).

Figure 3. A, Preoperative view of a 24-year-old woman. B, Postoperative view 1 year after rhinoplasty with luxation technique. (figure continued on next page)
Figure 3—cont’d. C, E, G, Preoperative views of a 24-year-old woman. D, F, H, Postoperative views 1 year after rhinoplasty with luxation technique.
References


Suggested Readings


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