PREOPERATIVE DIAGNOSES:,1. Nasal obstruction secondary to deviated nasal septum.,2. Bilateral turbinate hypertrophy.,PROCEDURE:, Cosmetic rhinoplasty. Request for cosmetic change in the external appearance of the nose.,ANESTHESIA: , General via endotracheal tube.,INDICATIONS FOR OPERATION: ,The patient is a 26-year-old white female with longstanding nasal obstruction. She also has concerns with regard to the external appearance of her nose and is requesting changes in the external appearance of her nose. From her functional standpoint, she has severe left-sided nasal septal deviation with compensatory inferior turbinate hypertrophy. From the aesthetic standpoint, the nose is over projected, lacks rotation, and has a large dorsal hump. First we are going to straighten the nasal septum and reduce the size of the turbinates and then we will also take down the hump, rotate the tip of the nose, and de-project the nasal tip. I explained to her the risks, benefits, alternatives, and complications for postsurgical procedure. She had her questions asked and answered and requested that we proceed with surgery as outlined above.,PROCEDURE DETAILS: , The patient was taken to the operating room and placed in supine position. The appropriate level of general endotracheal anesthesia was induced. The face, head, and neck were sterilely prepped and draped. The nose was anesthetized and vasoconstricted in the usual fashion. Procedure began with a left hemitransfixion incision, which was brought down into the left intercartilaginous incision. Right intercartilaginous incision

was also made and the dorsum of the nose was elevated in the submucoperichondrial and subperiosteal plane. Intact bilateral septomucoperichondrial flaps were elevated and a severe left-sided nasal septal deviation was corrected by detachment of the caudal nasal septum from the maxillary crest in a swinging door fashion and placing it back into the midline. Posterior vomerine spur was divided superiorly and inferiorly and a large spur was removed. Anterior and inferior one-third of each inferior turbinate was clamped, cut, and resected. The upper lateral cartilages were divided from their attachments to the dorsal nasal septum and the cartilaginous septum was lowered by approximately 2 mm. The bony hump of the nose was lowered with a straight osteotome by 4 mm. Fading medial osteotomies were carried out and lateral osteotomies were then created in order to narrow the bony width of the nose. The tip of the nose was then addressed via a retrograde dissection and removal of cephalic caudal semicircle cartilage medially at the tip. The caudal septum was shortened by 2 mm in an angle in order to enhance rotation. Medial crural footplates were reattached to the caudal nasal septum with a projection rotation control suture of #3-0 chromic. The upper lateral cartilages were rejoined to the dorsal septum with a #4-0 plain gut suture. No middle valves or bone grafts were necessary. Intact mucoperichondrial flaps were closed with 4-0 plain gut suture and Doyle nasal splints were placed on either side of the nasal septum. The middle meatus was filled with Surgicel and Cortisporin otic and external Denver splint was applied with

sterile tape and Mastisol. Excellent aesthetic and functional results were thus obtained and the patient was awakened in the operating room, taken to the recovery room in good condition.