PREOPERATIVE DIAGNOSES: ,1. Posttraumatic nasal deformity.,2. Nasal obstruction.,3. Nasal valve collapse.,4. Request for cosmetic change with excellent appearance of nose.,POSTOPERATIVE DIAGNOSES:,1. Posttraumatic nasal deformity.,2. Nasal obstruction.,3. Nasal valve collapse.,4. Request for cosmetic change with excellent appearance of nose.,OPERATIVE PROCEDURES:,1. Left ear cartilage graft.,2. Repair of nasal vestibular stenosis using an ear cartilage graft.,3. Cosmetic rhinoplasty.,4. Left inferior turbinectomy.,ANESTHESIA: , General via endotracheal tube.,INDICATIONS FOR OPERATION: , The patient is with symptomatic nasal obstruction and fixed nasal valve collapse following a previous nasal fracture and attempted repair. We discussed with the patient the indications, risks, benefits, alternatives, and complications of the proposed surgical procedure, she had her questions asked and answered. Preoperative imaging was performed in consultation with regard to aesthetic results and communicated via the computerized imager. The patient had questions asked and answered. Informed consent was obtained.,PROCEDURE IN DETAIL: , The patient was taken to the operating room and placed in supine position. The appropriate level of general endotracheal anesthesia was induced. The patient was converted to the lounge chair position, and the nose was anesthetized and vasoconstricted in the usual fashion. Procedure began with an inverted going incision and elevation of the skin of the nose in the submucoperichondrial plane over the medial crural footplates and lower lateral cartilages and up

over the dorsum. The septal angle was approached and submucoperichondrial flaps were elevated. Severe nasal septal deviation to the right hand side and evidence of an old fracture with a separate alignment of the cartilaginous nose from the bony nose was encountered. The upper laterals were divided and medial and lateral osteotomies were carried out. Inadequate septal cartilage was noted to be present for use as spreader graft; therefore, left postauricular incision was made, and the conchal bowl cartilage graft was harvested, and it was closed with 3-0 running locking chromic with a sterile cotton ball pressure dressing applied. Ear cartilage graft was then placed to put two spreader grafts on the left and one the right. The two on the left extended all the way up to the caudal tip, the one on the right just primarily the medial wall. It was placed in such a way to correct a caudal dorsal deviation of the nasal tip septum. The upper lateral cartilage was noted to be of the same width and length in size. Yet, the left lower cartilage was scarred and adherent to the upper lateral cartilage. The upper lateral cartilages were noted to be excessive of uneven length with the right being much taller than the left and that was shortened to the same length. The scar bands were released in the lower lateral cartilages to the upper lateral cartilages to allow free mobilization of the lower lateral cartilages. A middle crus stitch was used to unite the domes, and then the nose was projected by suturing the medial crural footplates of the caudal septum in deep projected fashion. Crushed ear cartilage was then placed in the pockets above the spreader grafts in the area of the

deficient dorsal nasal height and the lateral nasal sidewall height. The spreader brought an excellent aesthetic appearance to the nose. We left more than 1 cm of dorsal and caudal support for the nasal tip and dorsum height. Mucoperichondrial flaps were closed with 4-0 plain gut suture. The skin was closed with 5-0 chromic and 6-0 fast absorbing gut. Doyle splints were placed on each side of nasal septum and secured with 3-0 nylon and a Denver splint was applied. The patient was awakened in the operating room and taken to the recovery room in good condition.