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Abstract

Thoralf Stange: Nasal Septum Defect Repair and Rhinoplasty: A One-Stage or Two-Stage Procedure?

Introduction: Both spontaneous and postoperative nasal septal defects are often accompanied by additional deformities of the external nose. Planning the surgical approach is complicated, first, by the very challenging tissue conditions resulting from scarred and partially destroyed anatomical structures. Second, it is unclear whether internal and external pathologies can be treated simultaneously. Of course, surgical correction in a single session is both elegant and convenient for the patient. Therefore, based on the author's personal experience over the past 5 years, this article will explain—both statistically and through several case examples—in which cases both corrections can be performed simultaneously and in which cases a two-stage approach is preferable.

Method: From 2008 to 2012, the author performed surgery on 278 nasal septal defects using the modified Schultz-Coulon bridge flap technique, and in 63 cases, external rhinoplasty was performed simultaneously. After measurement, the defects were divided into 4 groups: Small septal defects (Type I) occupied a maximum of one-third of the septal height in the defect area; medium-sized defects (Type II) were between one-third and one-half of the septal height in the defect area; large defects (Type III) were between one-half and two-thirds; and very large septal defects (Type IV) were greater than two-thirds of the septal height in the defect area. The follow-up period was at least 12 months.

Results: Of the nasal septal defect repairs performed without rhinoplasty (-R), 91% were completely closed. When rhinoplasty (+R) was performed concurrently, the complete closure rate was 74%. Different success rates were observed for the various defect sizes: Small defects without rhinoplasty (Type I – R) 97% / with rhinoplasty (Type I + R) 85%; medium-sized defects (Type II – R) 96% / (Type II + R) 59%; large defects (Type III – R) 66% / (Type III + R) 40%; very large defects (Type IV – R) 33%. No additional rhinoplastic procedures were performed for Type IV defects.

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Conclusions: It can thus be concluded that, for small nasal septal defects, additional rhinoplastic procedures can be performed without significantly compromising the prognosis for complete closure. For medium-sized defects, a two-stage procedure should be chosen whenever possible, and additional rhinoplastic procedures should be performed only in selected cases (e.g., primary surgery, nasal dorsum reduction), as otherwise the prognosis for complete closure decreases significantly. For large defects, a two-stage procedure should always be planned.