



## GUIDELINES

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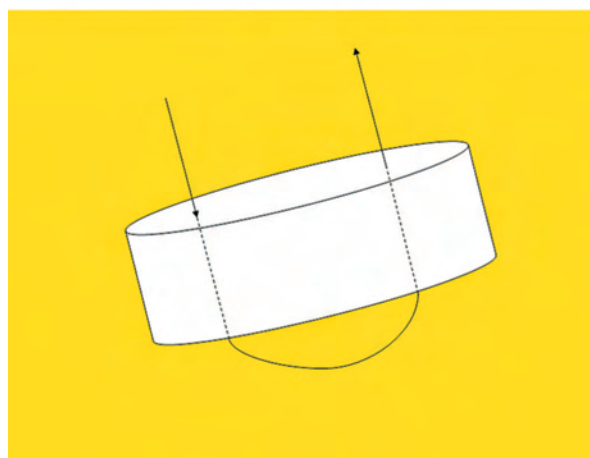
## Tip Grafts in Closed Rhinoplasty: Insertion and Fixation Made Easy

**Sir:**

If the closed technique is to be used, after preparing the tip graft, the next step is to place it into a subcutaneous pocket made from one rim incision in the right or left vestibule. Sometimes this procedure may be quite difficult and troublesome and can result in graft malposition, especially if graft fixation is to be achieved with sutures through the skin. Such drawbacks make some surgeons elect to use the open technique when dealing with tip grafts.

A simple method of inserting the cartilage graft (to project the nasal tip) is through one rim incision in one of the vestibules. After the tip pocket is created, a section lifter (with its concave surface toward the skin) (Fig. 1) is used to guide the 6-0 nylon needle safely from the tip skin to the vestibule. After the needle has passed through the cartilage graft(s) (Fig. 1), the same section lifter is used to guide needle on its safe return route

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**Fig. 1.** (Above) Section lifter passing through one rim incision. Its concave surface safely guides the needle from the nasal skin to the nasal vestibule. (Below) The suture is passed through the cartilage graft.

from the vestibule to the tip skin. Pulling both suture extremities through the tip skin will orient the graft to the correct position in the tip subcutaneous pocket. The suture is tied loosely over a small piece of cotton and left in place for only 24 hours.

DOI: 10.1097/01.prs.0000300221.07515.d2

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## A New and Simple Marker for the Transcartilaginous Incision: The Cabas-Coffler Marker

**Sir:**

**W**hen performing a closed rhinoplasty using Peck's marking technique,<sup>1</sup> one designs the transcartilaginous incision to resemble a gull's wing. As part of the technique, the initial local infiltration of anesthesia should not distort the tip. Next, the suction tip is placed intranasally in the dome area to imprint the initial site of the transcartilaginous incision.<sup>1</sup> For some time, this maneuver has proved quite difficult to perform with accuracy, because the suction tip will only provide a round and limited imprint of the externally designed incision.

We have designed a simple marker that is able to imprint a dotted line in the vestibular skin that reflects exactly the line that has been drawn on the external skin. Known as the Cabas-Coffler marker (Fig. 1), it was created from a standard Allis forceps by rasping one side to make it smooth in order not to damage the nasal tip skin; the opposite side (i.e., the side that will imprint the dotted line in the nasal vestibular skin) was made sharper.

At first we used methylene blue dye to print the transcartilaginous incision in the vestibule. Today we find that totally unnecessary. By using the marker without any dye, a dotted line can still be obtained without blurring the vestibular skin (Fig. 2).

DOI: 10.1097/01.prs.0000300187.44113.f0

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**Fig. 1.** (Left) The Allis forceps. (Right) Removing the teeth from one side of the Allis forceps and deepening those on the opposite side will create the Cabas-Coffler marker.



**Fig. 2.** The marker transfers the "gull's wing" line to the vestibular skin, thus making the incision more precise.

#### Arterial Embolization and Skin Necrosis of the Nasal Ala following Injection of Dermal Fillers

Sir:

**T**he most common adverse effects of injection of biodegradable dermal fillers are bruising and erythema in the acute phase and allergic changes, abscess formation, and granulomatous change in the chronic phase.<sup>1-3</sup> The most serious side effect is localized tissue necrosis, which is induced by mechanical interruption of local vascularity, though it occurs very rarely (nine in 10,000 patients who underwent collagen implantation).<sup>2</sup> The only reported case of arterial embolization induced by hyaluronic acid injection involved the glabellar region.<sup>4</sup>

A 50-year-old Japanese woman with no previous history of cosmetic surgery underwent injection of hyaluronic acid gel (Restylane; Q-Med, Uppsala, Sweden) to shape the nasal tip contour and of human tissue-derived, reconstituted collagen matrix (Sheba; Hans Biomed, Daejeon, South Korea) for wrinkle correction of the upper white lip and nasolabial fold and augmentation of the upper vermilion. Immediately after the injection, the patient had a striking pain on the left side of her face. A few hours later she noticed reddish discoloration from the left side of the nose and upper lip to the glabellar region, which corresponded to the area nourished by the angular branch of the facial artery. By the third day of onset, blisters had appeared at the left nasal ala. When the patient consulted our hospital on the sixth day, a gangrenous skin necrosis measuring 1 × 1.5 cm was present on the left nasal ala (Fig. 1). Three-dimensional computed tomographic angiography performed on the ninth day demon-

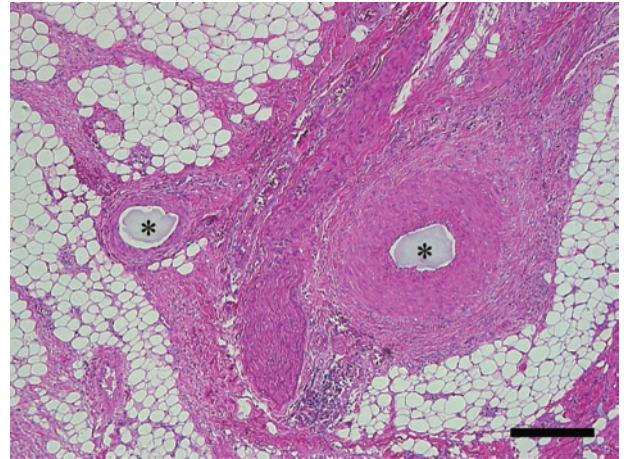


**Fig. 1.** View of the patient on her first visit (6 days after injection). Gangrenous skin necrosis is seen on the left nasal ala. Erythema was seen on the whole area nourished by the angular branch of the facial artery (i.e., the glabellar region, the left side of the nose, and the left upper lip).

strated local occlusion of the angular branch of the facial artery and compensatory dilation of collateral vessels such as the infraorbital artery and its daughter branches. Intravenous administration of alprostadil (Prostandin; 120  $\mu\text{g}/\text{day}$ ) was then started, and the surrounding erythema decreased with time. The necrosis extended to the surrounding skin and subcutaneous tissue, and was surgically removed on the twelfth day. A full-thickness skin graft taken from the postauricular area was grafted to the residual skin defect on the day 43 and was successfully accepted.

In the present case, the alar skin resulted in massive necrosis, despite the absence of filler injection into the ala. Histopathological examination of the biopsy specimen from the nasal ala indicated intra-arterial and subdermal deposition of foreign bodies (Fig. 2), although we could not identify whether they were Restylane or Sheba. Sharp pain and the erythema in the early phase suggest acute and widespread embolization of the artery. Together with the results of the three-dimensional computed tomographic angiography, we diagnosed the patient as having arterial embolizations of the angular branch and its daughter branches.

Like the glabellar region, the nasal ala may be a particular region in which blood supply depends strongly on a single arterial branch. Otherwise, collateral blood supply was blocked by the concurrent filler injection to the nasal tip, which may have been a critical factor in this case. Although accidental intra-arterial injection of dermal fillers is apparently rare, the po-



**Fig. 2.** Debridement sample. Photomicrograph of subcutaneous tissue shows intra-arterial foreign bodies (\*) and thickening of the intima (hematoxylin and eosin stain; scale bar = 300  $\mu\text{m}$ ).

tential risk of vascular embolization should be noted, especially when injecting into the subcutis of the glabellar region, the nasal ala, and the nasolabial folds.

DOI: 10.1097/01.prs.0000300188.82515.7f

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