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CORRECTION OF DEFORMITY OF THE BACK AND END OF THE NOSE USING THE "OPEN" METHOD

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One of the most complex and important sections of facial reconstructive surgery is the implementation of reconstructive and corrective operations aimed at eliminating nasal deformities. Along with the increase in the number of patients with congenital and post-traumatic deformities of the nose, defects after treatment of oncological diseases, in recent years the number of patients with the consequences of unsuccessful aesthetic surgeries has increased significantly.

Methods for surgical correction of nasal deformities are of particular interest, because... the presence of deformation of the nose (in particular, its terminal section) leads not only to cosmetic defects and psychological problems, but also to serious functional disorders in the form of difficulty in nasal breathing. Thus, the problem of using various materials to eliminate nasal deformities remains one of the current topics.

We observed 84 patients who underwent rhinoplasty. The operation was performed under sedation, under endotracheal anesthesia, carried out according to a standard scheme. The patient's face and neck are treated twice with a 70% alcohol solution, the nasal passages are aseptically treated and tamponed with turundas moistened with an antiseptic solution. In the area of surgical intervention, hydropreparation of soft tissues is performed with saline solution with the addition of adrenaline (0.25 ml of 0.1% solution per 200 ml of saline solution). When using local anesthesia, the saline solution is replaced with a local anesthetic solution.

When performing an operation using this technique, surgical access from the nasal cavity is used. An anterior vestibular incision is made with a V-shaped transition to the skin part of the nasal septum. Bluntly and sharply, with the help of scissors and a rasp, the skin of the tip, dorsum and slopes of the nose is peeled off wider than the predetermined boundaries by 0.5-1 cm, depending on the degree of deformation of the nasal dorsum. If it is necessary to significantly increase the volume of soft tissue above the nasal bones, detachment can be carried out to the infraorbital-buccal areas.

If necessary, we used an autoimplant made from nasal septum cartilage to lift the bridge of the nose. In the area of the nasal bones, a triangular periosteal flap is cut out with a scalpel to fix the upper part of the implant subperiosteally. Hemostasis is performed. To facilitate insertion of the implant into the bed, the assistant lifts the soft tissue with a hook or rasp, and the surgeon inserts a silicone implant, fixing it with a direct Billroth clamp. If necessary, 1-2 fixing sutures are placed between the wing cartilages and the end of the implant with a 4/0 – 5/0 absorbable thread. If, after installing the implant, a lack of length of the skin part of the nasal septum is detected, then the V-shaped incision is converted into a Y-shaped one. Thus, the skin part of the nasal septum is lengthened by 0.3-0.5 cm. Separate interrupted 6/0 monofilament sutures are placed on the incisions in the area of the mucous membrane and the skin part of the nasal septum. Special splints made of silicone are installed in the nasal cavity. A modeling plaster cast is applied to the bridge of the nose. The nasal passages are loosely tamponed with turundas with antiseptic ointment (Levomekol ointment, Syntomycin emulsion 10%, etc.). Aseptic dressing on the tip of the nose.

The choice of surgical approach must be decided on an individual basis, but priority is given to that part of the operation that facilitates the subsequent stage. Patients after rhinoplasty in the postoperative period must undergo careful care of the nasal cavity in order to prevent the formation of synechiae and cicatricial adhesions, as well as dynamic monitoring of patients after discharge until complete recovery.

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