

The Dallas Rhinoplasty Dissection Guide

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Open Rhinoplasty Approach—Transcolumellar Incision

A stair-step transcolumellar incision with infracartilaginous extensions is preferred. The transcolumellar incision is marked and continued into the infracartilaginous incisions. The transcolumellar incision is made first. The infracartilaginous incisions are made starting from lateral to medial (**Fig. 1**).

The tip skin is elevated initially from the columella to the infratip and then from lateral to medial over the lower lateral crura. In order to protect the cartilage, a double hook is placed in the soft triangle and the dissected pockets are connected. The tip skin is elevated off the perichondrium to expose the tip cartilages and is connected to the dorsal undermining. Dissection is performed with a combination of sharp and spreading techniques.

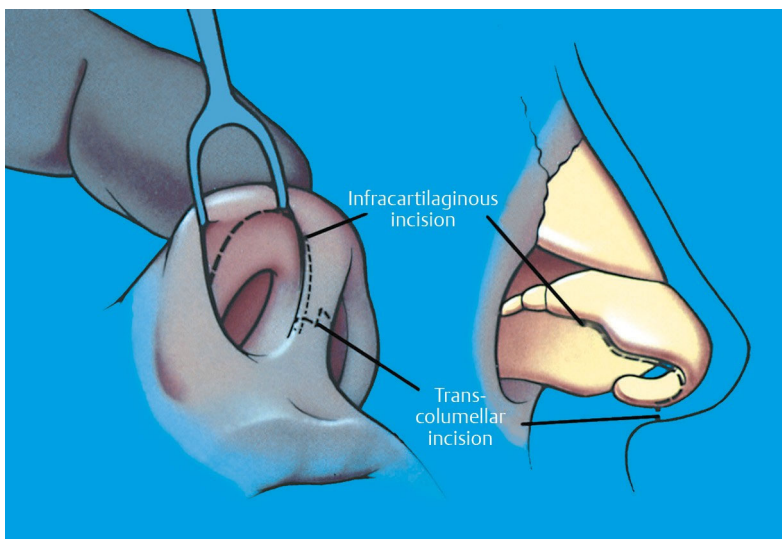


Fig. 1 Stair-step transcolumellar incision with infracartilaginous extensions. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

Modification of the Dorsum—Component Dorsal Hump Reduction

With a Joseph periosteal elevator, start at the osteocartilaginous junction and elevate the periosteum off the nasal bones. Elevation should be done centrally only enough to allow modification of the dorsum, while lateral soft-tissue attachments are preserved.

Identify the anterior septal angle. The perichondrium is scored on both sides with a #15 blade and then, using a Cottle elevator, bilateral mucoperichondrial tunnels are dissected off the dorsal septal cartilage at its junction with the upper lateral cartilages. Through the tunnels, separate the upper lateral cartilage from the septum with a #15 blade. Under direct visualization, the mucoperichondrium is elevated further from the dorsal septal edge bilaterally. The mucoperiosteum is also elevated from the deep surface of the nasal bones medially and from the perpendicular plate of the ethmoid, to expose the dorsal septum requiring modification. This will preserve the mucosa of the internal valves (**Fig. 2**).

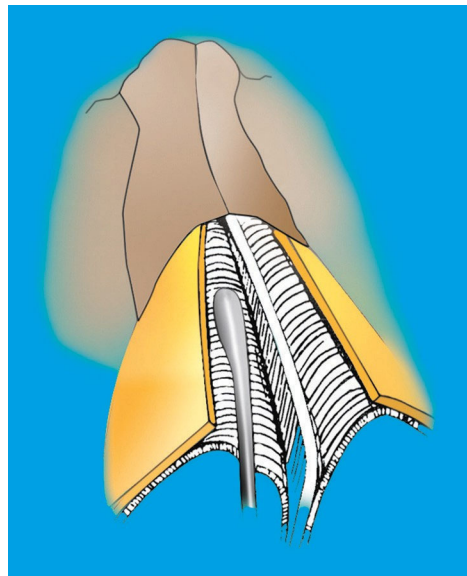


Fig. 2 Component dorsal hump reduction. Bilateral submucoperichondrial tunnels are dissected off the dorsal septal cartilage using a Cottle elevator. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

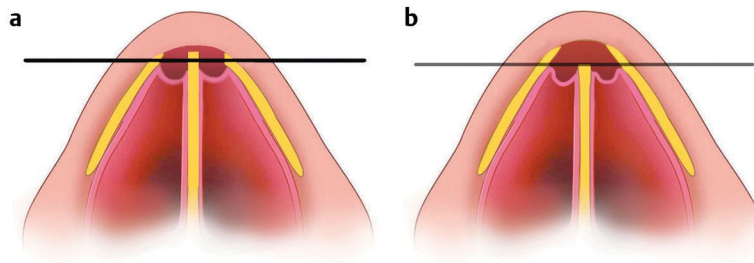


Fig. 3 (a,b) Angled septal scissors are used to reduce the dorsal septum to its desired height. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

Angled septal scissors are used to reduce the dorsal septum to its desired height (**Fig. 3**). This cartilage can be used as graft material. A Fomon rasp is used to lower the bony dorsum. The rasping is performed using slight oblique strokes with short excursions. During rasping, the cephalic ends of the upper lateral cartilages beneath the bony dorsum are pushed posteriorly to avoid resection. The nasal skin is redraped intermittently to assess the contour of the dorsum by three-point palpation.

Septal Reconstruction and Inferior Turbinate Surgery

Microfracturing of the Inferior Turbinates

Using a nasal speculum, the anterior portion of the inferior turbinate is identified. The bony portion of the inferior turbinate is microfractured outward from posterior to anterior with a nasal speculum and then is removed (**Fig. 4**).

Septal Reconstruction

Starting at the anterior septal angle, a #15 blade is used to score through the perichondrium bilaterally. A Cottle elevator is used to elevate the submucoperichondrial pockets superiorly and posteriorly first and then toward the floor of the nose to the junction of the septum with the maxillary crest (**Fig. 5**). This dissection is extended posteriorly along the crest. The mucoperichondrium is elevated off the rest of the nasal septum and the perpendicular plate.

Using a #15 blade and starting at the perpendicular plate, the septal cartilage is incised 15 mm posterior and parallel to the dorsal septal edge down to within 15 mm of the caudal septum (**Fig. 6**). At the caudal edge of this incision, an incision is made parallel to the caudal septum, leaving a 15-mm caudal strut down to the

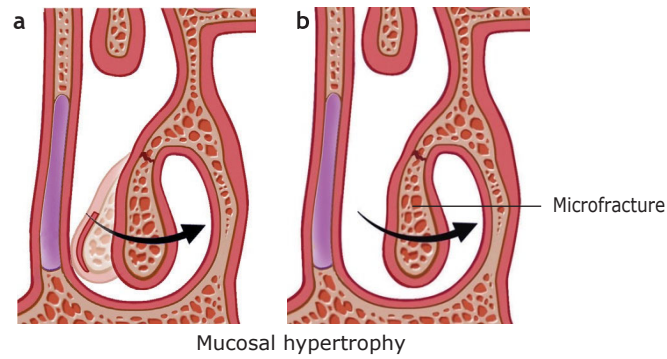


Fig. 4 (a,b) Microfracturing of the inferior turbinates. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

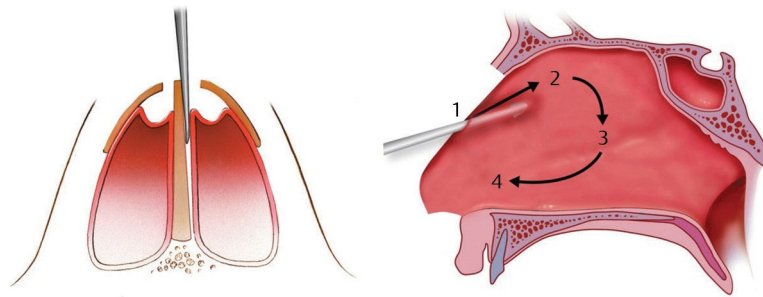


Fig. 5 Elevation of the submucoperichondrial pockets superiorly and posteriorly first and then toward the floor of the nose to the junction of the septum with the maxillary crest using a Cottle elevator. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

maxillary crest. Angled septal scissors are used to cut the ethmoid bone in a posterior direction and the posterior septum is microfractured posteriorly, inferiorly, and along the maxillary crest to free the septum. The septum should now be free to harvest while preserving the anterior septal L-strut. It must be completely detached and mobile to prevent fracture into the cribriform plate.

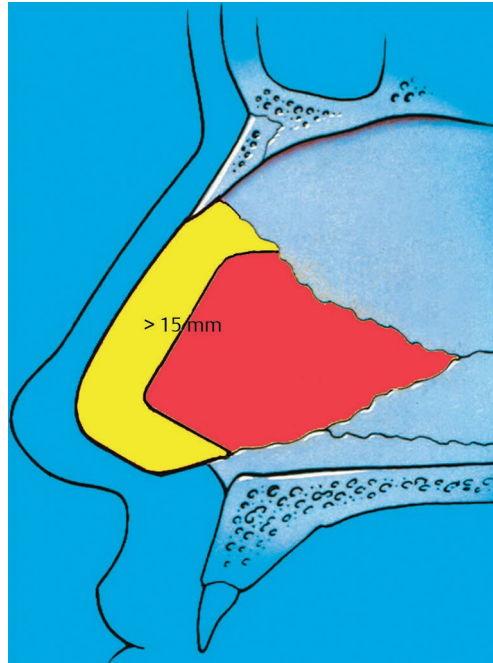


Fig. 6 Starting at the perpendicular plate, the septal cartilage is incised 15 mm posterior and parallel to the dorsal septal edge down to within 15 mm of the caudal septum. (Reproduced with permission from Rohrich RJ, Adams WJr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

The remainder of the posterior septum can be microfractured using a Cottle elevator and repositioned to the midline. If there is deviation of the posterior bony septum, the deviated bony septum can be carefully removed using Takahashi forceps.

Midline Septal Repositioning

Skin hooks are used to retract the medial crura laterally. Soft tissue is undermined off the crura, and the caudal septum is exposed. Caudal septal deviation is corrected by release of the caudal septum from the anterior nasal spine and maxillary crest.

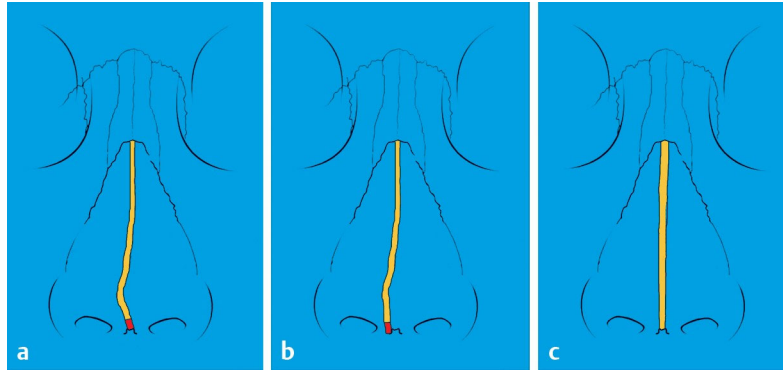


Fig. 7 (a–c) Midline septal repositioning. The vertical excess is excised and the caudal L-strut is repositioned to the midline using sutures placed through the caudal septum into the periosteum of the anterior nasal spine. (Reproduced with permission from Rohrich RJ, Adams WJr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers, 2014.)

The vertical excess is excised and the caudal L-strut is repositioned to the midline using sutures placed through the caudal septum into the periosteum of the anterior nasal spine (**Fig. 7**).

Reconstruction of the Midvault

Upper Lateral Cartilage Tension-Spanning Sutures

After component dorsal hump reduction, the dorsal edges of the upper lateral cartilages may need to be trimmed. Upper lateral cartilage tension-spanning sutures are performed to reconstitute the midvault. These sutures travel from the dorsal edges of the upper lateral cartilages to the dorsal edge of the septum (**Fig. 8**).

Prior to this part of the anatomy lab, remove the upper lateral cartilage tension-spanning sutures.

Spreader Graft (Right)

Reduction of the dorsal septum may decrease the angle between the septum and the upper lateral cartilages. Reconstruction of the internal nasal valve is accomplished using autogenous spreader grafts (**Fig. 9**). A 25 by 3 mm piece of the silicone sheeting is placed between the mucoperichondrium of the upper lateral cartilage and septum. If indicated, the spreader graft can be positioned below the dorsal edge of the septum to make it less visible and prevent widening the midvault.

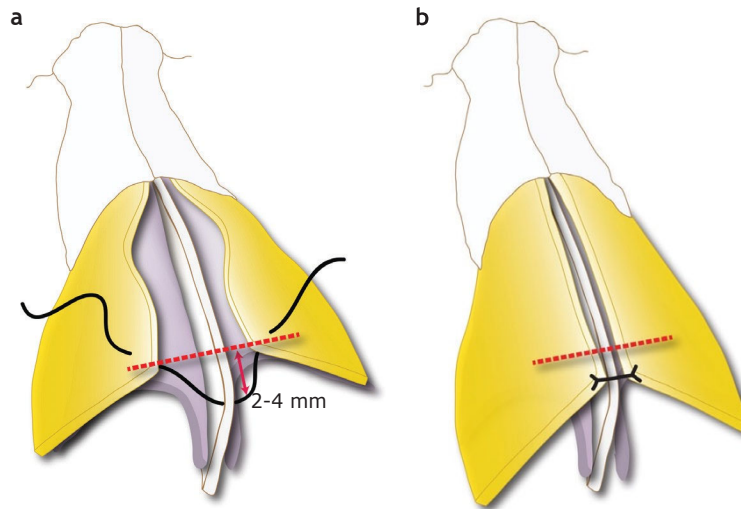


Fig. 8 (a,b) Upper lateral cartilage tension-spanning sutures. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

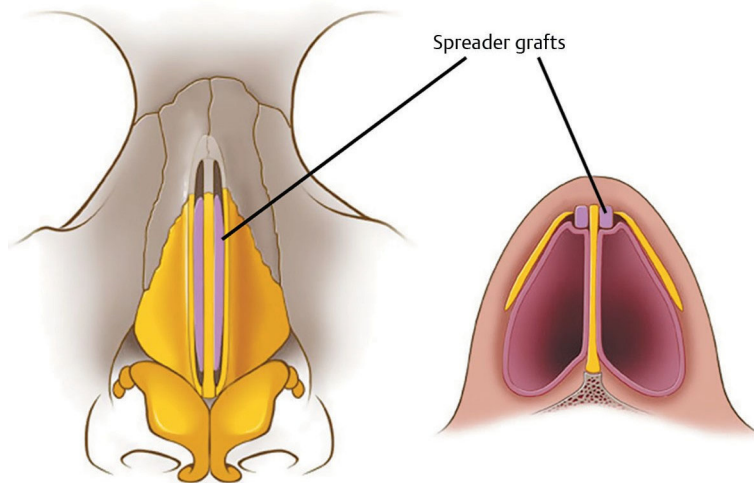


Fig. 9 Reconstruction of the internal nasal valve is accomplished using autogenous spreader grafts. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

Through-and-through 5-0 mattress sutures are placed from the graft into the septum, firmly securing them into position. Both the airway and dorsal aesthetic lines are improved by the use of these grafts.

Autospreader Flap (Left)

An autospreader flap is used to adjust the height of the upper lateral cartilages while simultaneously preserving function of the internal nasal valve. The superficial surface of the dorsal edge of the upper lateral cartilage is rolled inward and scored if necessary. The cartilage flap is rotated medially and secured to the septum with two or three sutures. This maintains dorsal height by using the normally resected part of the upper lateral cartilage (**Fig. 10**).

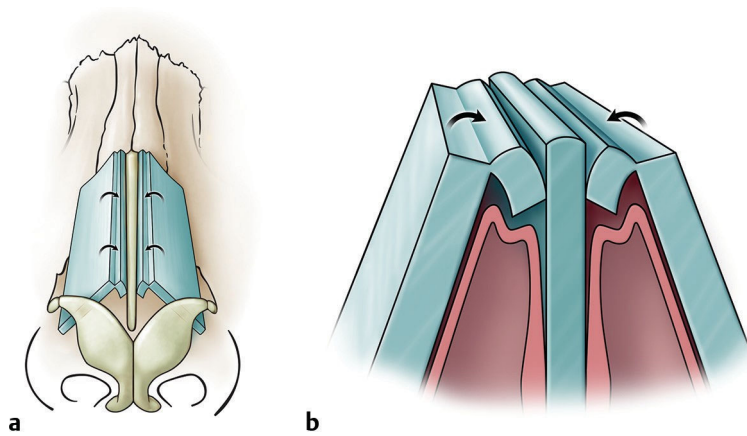


Fig. 10 (a,b) Autospreader flap. (Reproduced with permission from Rohrich RJ, Ahmad J. Secondary Rhinoplasty by the Global Masters. New York, NY: Thieme Publishers; 2016.)

Tip Alteration

Transnasal Depressor Septi Nasi Muscle Release

An overly dynamic depressor septi nasi muscle may decrease tip projection and lead to posterior and caudal tip rotation. The depressor septi nasi muscle may be modified by transnasal release (shown here) or transoral dissection and transposition (shown later).

Dissection in the columella is continued between the medial crural footplates. The depressor septi nasi muscle attachments to the medial crural footplates are identified and released.

Cephalic Trim (Right)

A cephalic trim is indicated when the domes are bulbous or boxy (**Fig. 11**). Cephalic trim can be performed only on the lateral crus or can be extended to include the middle crus as well. The width of the right lateral crus is measured and left 5 to 6 mm to create dome definition. Using sharp-angled scissors, the cephalic portion of the lower lateral cartilage is excised starting at the middle crus and continuing along the lateral crus. Cartilage may be saved for grafting when indicated. This cartilage is especially useful as a butterfly graft (shown later).

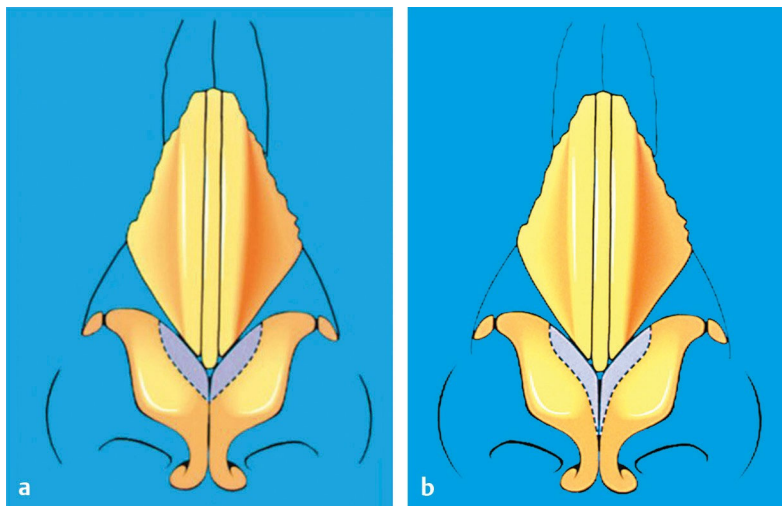


Fig. 11 Cephalic trim. (Reproduced with permission from Rohrich RJ, Adams WJr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

Lower Lateral Crural Turnover Flap (Left)

An alternative technique to create dome definition while correcting a concave lateral crus or improve its strength is the lower lateral crural turnover flap (**Fig. 12**). The left lateral crus has been marked leaving a width of 5 to 6 mm. The cephalic edge of the lower lateral crus is dissected from the vestibular skin. Two-millimeter full-thickness cuts are made at the medial and lateral margins, and the remainder of the deep surface is scored using a #15 blade. The flap is rotated anteriorly and over the remaining lower lateral cartilage. Through-and-through horizontal mattress sutures are used to secure the flap in the correct position.

Septal Extension Graft

A septal extension graft is fashioned from silicone approximately 25 by 6mm. The graft is positioned onto the anterior septal angle with sufficient overlap for suturing. It projects into the interdomal space. The graft is placed perpendicular to vertical to maintain tip rotation, or is rotated or derotated to change tip rotation. It is secured with a 5-0 horizontal mattress fixation suture first. This is followed by stabilization sutures with 5-0 suture where the graft meets the septum superiorly and inferiorly. The final suture is another 5-0 horizontal mattress suture, placed posterior to the first mattress suture. This graft may be trimmed if there is excess graft after desired tip position is set.

Internal Medial Crural Footplate Suture

This suture is placed in the columellar base, plicating the medial crural footplates to correct displaced or asymmetric footplates and establish symmetry of the columellar base.

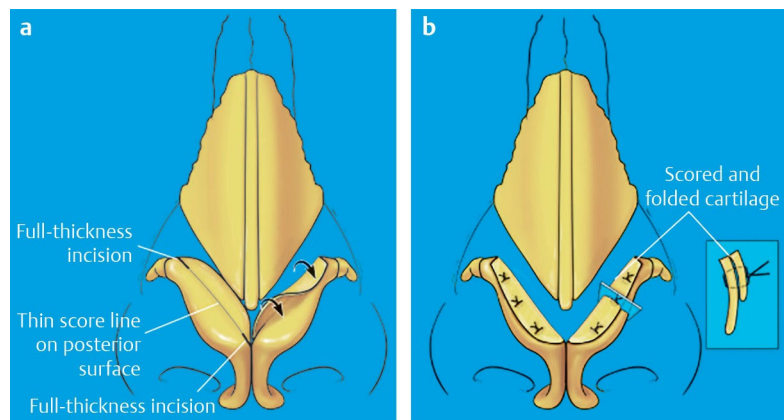


Fig. 12 (a,b) Lower lateral crural turnover flap. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

Columellar Strut Graft and Medial Crural Sutures

A columellar strut graft is fashioned from the silicone sheeting and trimmed to measure approximately 25 by 3 mm. Dissection is performed between the medial crura toward the anterior nasal spine, leaving a soft-tissue pad between the base of the pocket and the nasal spine. The columellar strut graft is then placed in the pocket (**Fig. 13**).

Double hooks are used to pull the tip defining points of the lower lateral crura upward to help set the position of the columellar strut between the feet of the medial crura and stabilize the strut for suturing (a low medial crural suture). A 5-0 suture

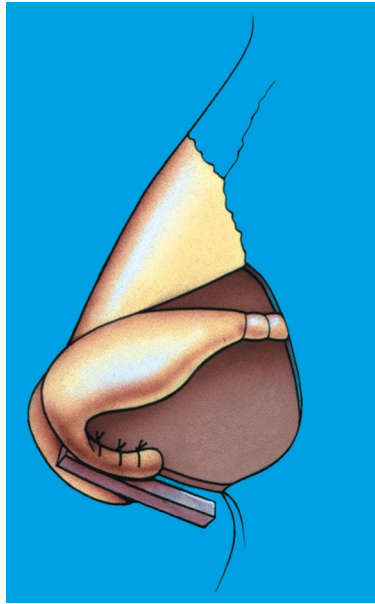


Fig. 13 Columellar strut graft and medial crural sutures. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

12 The Dallas Rhinoplasty Dissection Guide

is used to suture the medial crura to the columellar strut graft (**Fig. 14**). Additional superior intercrural sutures are placed to stabilize and unify the tip complex. The most superior suture is placed so that the medial portions of the domes can also be sutured to the columellar strut graft. If needed, the strut is trimmed to its desired shape to alter or refine the infratip lobular area (a high medial crural suture) (**Fig. 15**).

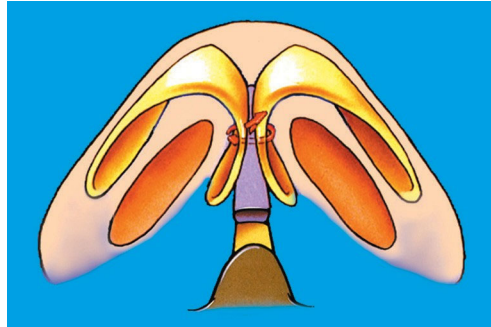


Fig. 14 After the position of the columellar strut is set, a 5-0 suture is used to suture the medial crura to the columellar strut graft. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

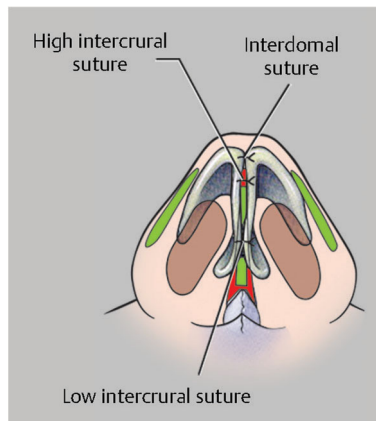


Fig. 15 Additional superior intercrural sutures are placed to stabilize and unify the tip complex. (Reproduced with permission from Rohrich RJ, Ahmad J. *Secondary Rhinoplasty by the Global Masters*. New York, NY: Thieme Publishers; 2016.)

Controlling Dome Angulation and Tip Defining Points

Transdomal Sutures

A caudal 5–0 horizontal mattress suture is placed from the medial surface of the dome through the lateral surface, staying deep to the vestibular skin (**Fig. 16**). It is passed back from lateral to medial. A double surgeon's knot is placed in the suture and tightened until the desired angulation of the dome is achieved. A second and a third knot are tied. One suture is cut short and the other left approximately 2.5 cm in length. The same procedure is performed on the opposite side, leaving one end of the suture long. The long end is tied to the remaining suture end on the opposite side. The knot is tightened until the desired distance exists between the tip defining points, and is then tied. This establishes the proper caudal superior tip point angulation and a straight lateral crura on basal view.

Interdomal Sutures

If indicated, a 5–0 simple suture is placed between the medial walls of the domes and tied to narrow the interdomal distance (**Fig. 17**).

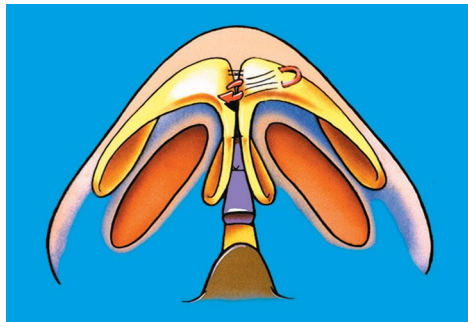


Fig. 16 Transdomal suture. A caudal 5–0 horizontal mattress suture is placed from the medial surface of the dome through the lateral surface, staying deep to the vestibular skin. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

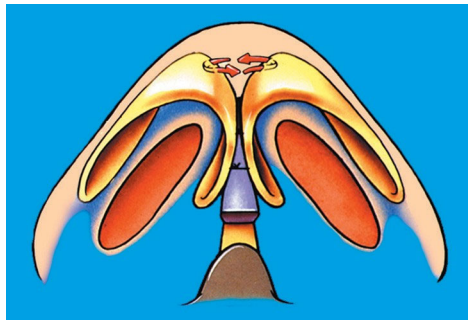


Fig. 17 Interdomal suture. A 5–0 simple suture is placed between the medial walls of the domes and tied to narrow the interdomal distance. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

Tip Grafts

Butterfly Graft

Using 5–0 sutures, a butterfly graft is sutured to the infratip and extends into and provides support to the soft-tissue triangles (**Fig. 18**).

Infratip Graft

A shield-shaped graft is cut from the silicone sheeting so that the top of the graft is approximately 8 mm in width. The width of the base of the graft is the same as the distance between the caudal margins of the medial crura. The length of the graft is 10 to 12 mm. The graft is placed so that it extends 2 to 3 mm beyond the tip defining points. The graft is secured in place with 5–0 sutures. Usually, two to three sutures are required to stabilize the graft (**Fig. 19**).

Onlay Tip Graft

An 8 by 6 mm onlay tip graft is contoured from the silicone sheeting and stabilized with 5–0 sutures to the tip defining points of the dome (**Fig. 20**).

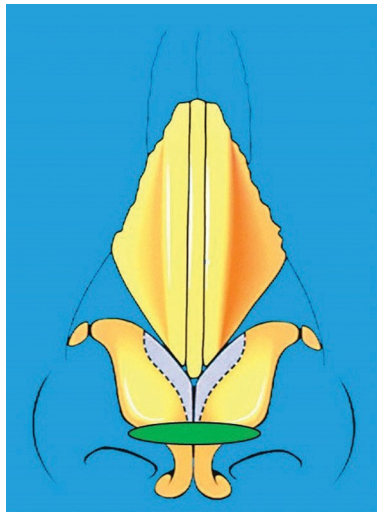


Fig. 18 Butterfly graft.

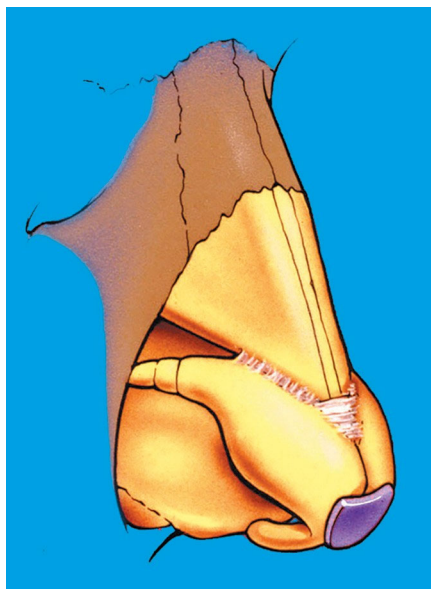


Fig. 19 Infratip graft. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

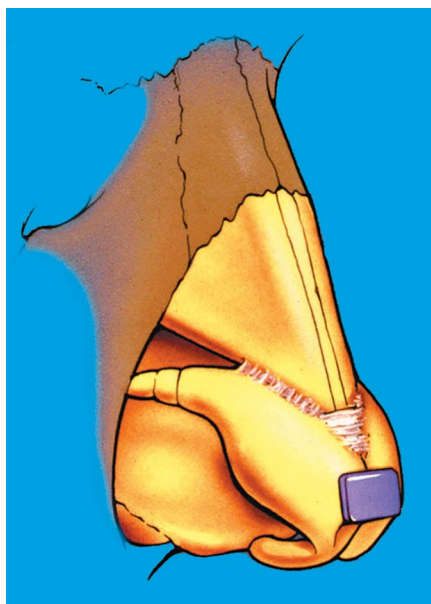


Fig. 20 Onlay tip graft. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

Osteotomies

Medial Nasal Osteotomy (Right)

The dorsal skin is retracted with an Aufricht retractor. A medial osteotomy is performed on the right side, placing a 7-mm osteotome on the edge of the nasal bone where it meets the dorsal septum, angling it laterally 15 degrees. The osteotomy is performed by lightly tapping the osteotome with a mallet, stopping at the level of the medial canthus.

Internal Lateral Nasal Osteotomy (Right)

The internal lateral nasal osteotomy is performed on the same side by spreading the nostril with the speculum and perforating the vestibular skin with sharp pointed scissors caudal to the attachment of the inferior turbinate. The scissors go down to the pyriform aperture rim and scratch the lateral rim to break through the periosteum. The curved osteotome is placed on the pyriform aperture rim approximately 3 mm anterior to the desired level of the osteotomy and is angled posteriorly at a 45-degree angle toward the desired level at the junction of the nose with the cheek.

The osteotomy is carried up to within 1 cm of the medial canthus and then it is continued superiorly until tapping of solid bone is heard. The nasal bone is fractured with the curved osteotome.

Percutaneous Perforated Lateral Nasal Osteotomy (Left)

On the opposite side, a percutaneous perforated lateral nasal osteotomy is accomplished with a sharp 2-mm osteotome placed parallel to the face of the maxilla at the level of the inferior orbital rim. The entry point is approximately 5 mm above the nasal cheek junction. The 2-mm osteotome is inserted beneath the periosteum at

this level and swept laterally to preserve the angular vessels. A low-to-low osteotomy is done with a light double tap using a mallet from the pyriform aperture to the level of the medial canthus. A superior oblique osteotomy is then performed at a 70-degree angle from the low-to-low osteotomy (**Fig. 21**). A gentle digital infracture will complete the osteotomy.

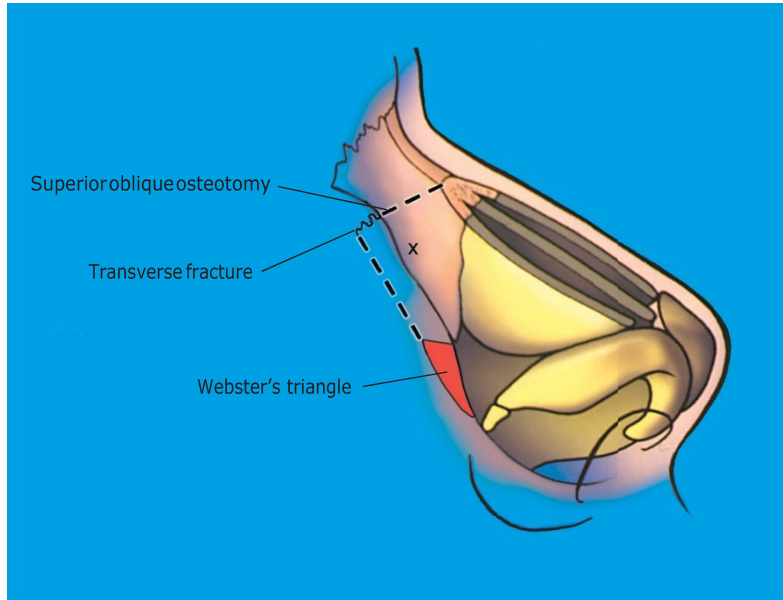


Fig. 21 Percutaneous perforated lateral nasal osteotomy. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. *Dallas Rhinoplasty: Nasal Surgery by the Masters*. 3rd ed. New York, NY: Thieme Publishers; 2014.)

Correction of Alar Pinching and/or Notching

Lateral Crural Strut Graft (Right)

The vestibular skin is undermined off the undersurface from the tip defining point to its junction with the accessory cartilages (**Fig. 22**). A pocket is undermined on the superficial surface of the accessory cartilage down to the pyriform aperture. A 25 by 3 mm strip of the plastic is cut. It is placed as a graft in the pocket on the undersurface of the lateral crus with the lateral end extending to the pyriform aperture. The graft is sutured to the lateral crus with two or three through-and-through 5-0 sutures.

Alar Contour Graft (Left)

Alar contour grafts are also used to correct alar pinching or notching (**Fig. 23**). On the left side, a subcutaneous pocket is made along the alar rim below the infracartilaginous incision with a curved sharp scissor. A 20 by 3 mm graft is fashioned from the plastic and placed in the pocket extending from the alar base to lateral crus. The medial edge of the graft protruding from the pocket is trimmed at an oblique angle. **Alternatively, they may be placed retrograde via the alar base resection when that step is performed.**

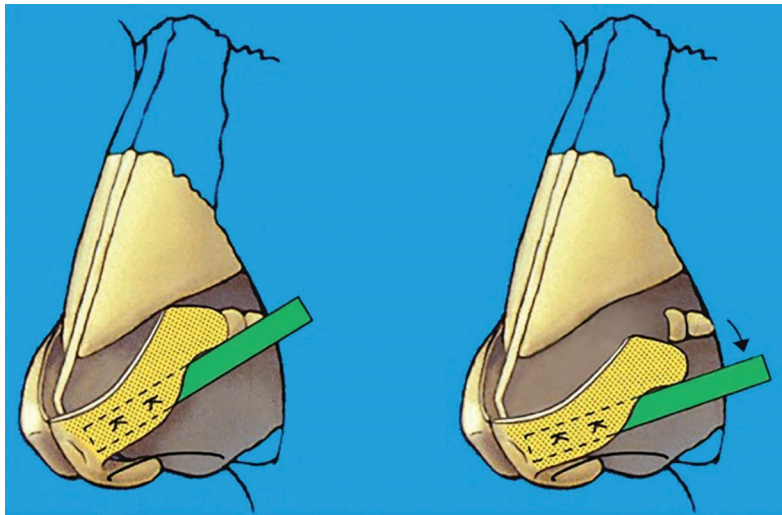


Fig. 22 Lateral crural strut graft. At the junction, or just medial to the junction of the lateral crus to the accessory cartilages, the cartilage is transected. (Reproduced with permission from Rohrich RJ, Adams WJr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

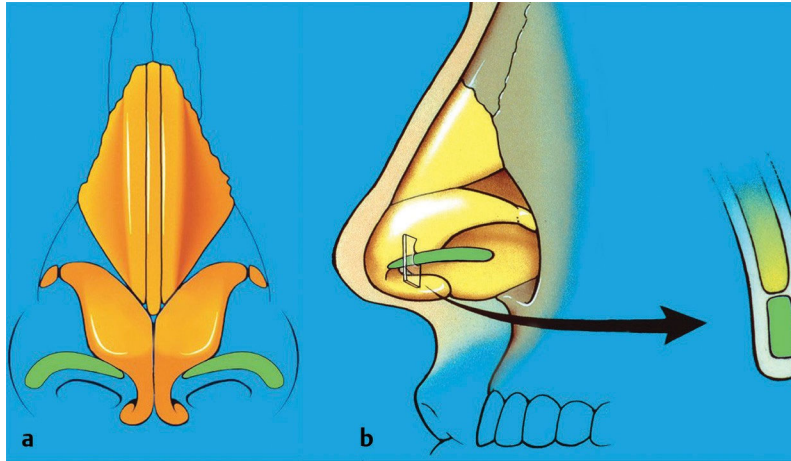


Fig. 23 (a,b) Alar contour graft. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

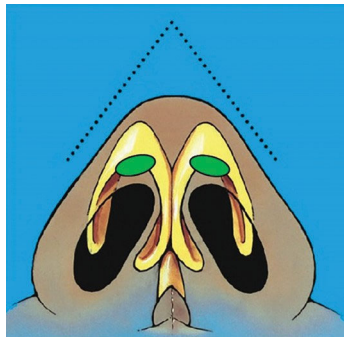


Fig. 24 Soft-tissue triangle graft.

Closure

Closure is accomplished by precisely aligning the transcolumnellar incision with 6–0 sutures. Care is taken to align the transition point between internal and external nasal skin to avoid notching of the transcolumnellar scar. The vestibular skin is reapproximated with 5–0 absorbable sutures. The incision superior to the soft-tissue triangles is not closed.

Soft-Tissue Triangle Grafts

After redraping the skin, a small amount of cartilage is crushed and this is inserted into the soft-tissue triangles (**Fig. 24**).

Adjunctive Techniques

Alar Base Resection—Correction of Alar Flaring (Right)

On the right side, **marking is started in the alar crease** and is extended superiorly to the most lateral point of the alar groove (**Fig. 25**). The medial and lateral points are connected to another line **is designed to leave 2mm of nostril sill intact, and pass through the most flared part of the ala**. The resection is designed to avoid transecting the nostril rim and maintain the nostril size. Both lines are incised, removing a wedge of soft tissue. The wound is closed with 6–0 sutures to carefully reapproximate and evert the skin edges.

Alar Base Resection—Correction of Alar Flaring, Diminishing Nostril Size, and Interalar Width (Left)

On the left side, the nostril rim is incised and the nostril made smaller (**Fig. 26**). The inferior resection extends into the nasal vestibule to include a nostril sill reduction

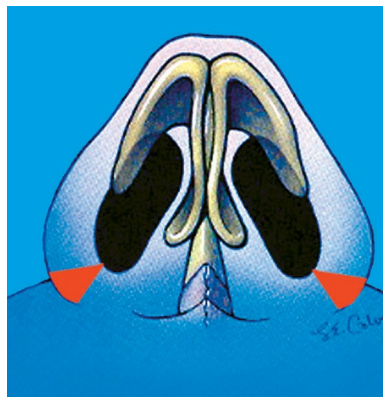


Fig. 25 Alar base resection—correction of alar flaring. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

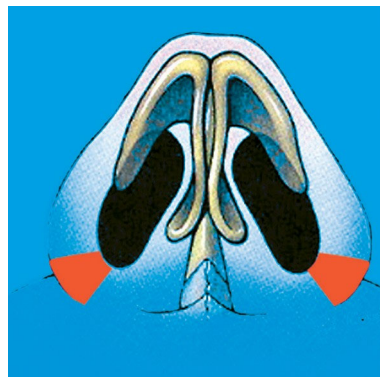


Fig. 26 Alar base resection—correction of alar flaring, nostril size, and interalar width. The nostril rim is incised and the nostril made smaller. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

with a medial curvilinear flap to avoid notching. A 4-mm full-thickness skin excision is performed to include a superior wedge of soft tissue as well. The skin edges are everted during closure with a 6-0 suture to avoid a depressed scar across the nostril sill.

External Medial Crural Footplate Approximation/Soft-Tissue Medial Crural Footplate Suture

Medial crural footplate approximation is used to improve the relationship between the medial crural footplates and the columellar base (**Fig. 27**). **5-0 absorbable sutures are passed through-and-through the vestibular skin and medial crura to reapproximate the medial crural footplates. Further sutures are placed through the membranous septum, around and through the septal extension graft.**

Transoral Depressor Septi Nasi Muscle Dissection and Transposition

An overly dynamic depressor septi nasi muscle may decrease tip projection and lead to posterior and caudal tip rotation. In patients with a short upper lip, a transoral approach to dissection and transposition of the depressor septi nasi muscle is used.

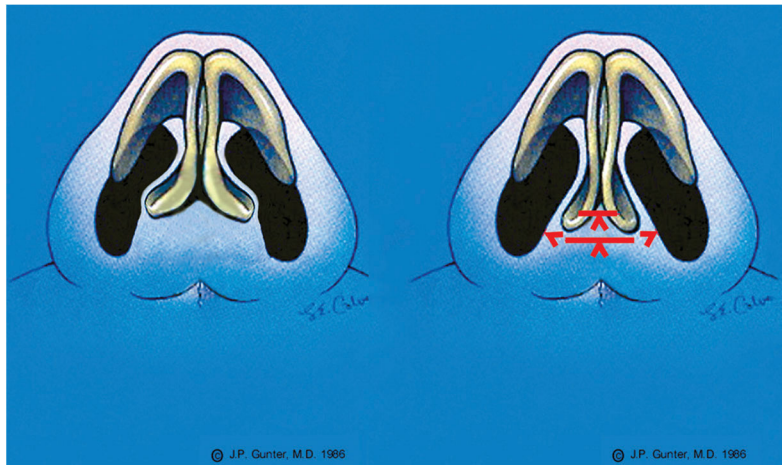


Fig. 27 External medial crural footplate approximation/soft-tissue medial crural footplate suture. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

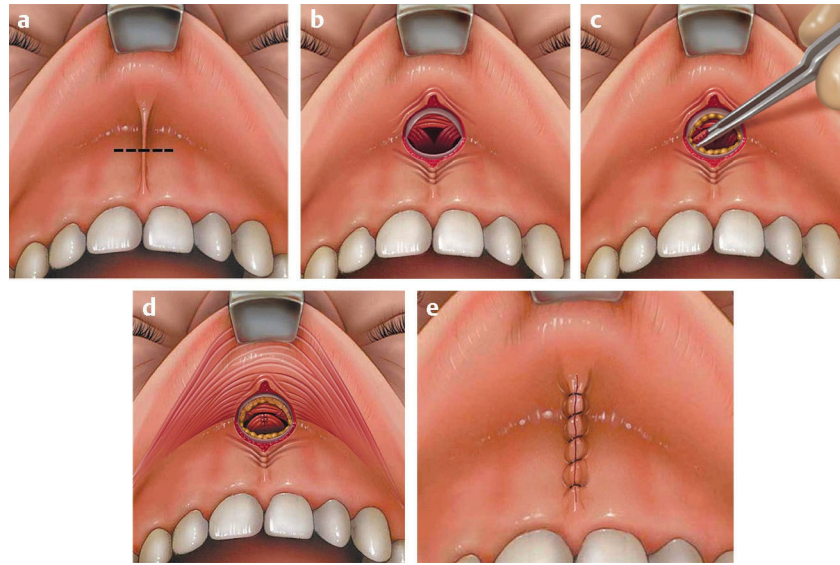


Fig. 28 (a–e) Transoral depressor septi nasi muscle dissection and transposition. (Reproduced with permission from Rohrich RJ, Adams W Jr, Ahmad J, Gunter J. Dallas Rhinoplasty: Nasal Surgery by the Masters. 3rd ed. New York, NY: Thieme Publishers; 2014.)

A transverse incision is made above the gingivobuccal sulcus and dissection is carried superiorly until the paired depressor septi muscles are identified. The muscles are freed by dissection and sutured together in the midline. The intraoral incision is closed vertically, further increasing the length of the upper lip (**Fig. 28**).

Splints

Doyle splints are placed with bayonet forceps after covering their surface with ointment. The splints are positioned under direct visualization such that their anteriormost aspect is at the level of the membranous septum. They are fixed and positioned with a through-and-through 3–0 mattress suture. Surgicel cut into small strips and impregnated with ointment are then placed behind the soft tissue triangle to further close dead space. The nasal skin is cleansed. Adhesive is applied, followed by Steri-Strips from the supratip to the radix. A contoured Denver splint is then applied.

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