
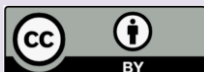



Diced Cartilage Fascia Technique with a Single Incision for Dorsal Augmentation in Rhinoplasty

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Original Research Article	Abstract:	DOI:
<p>Correspondence to: Prof Sayeed Ahmed Siddiky  sasiddiky@gmail.com</p> <p></p> <p>This open-access article is distributed under the terms of the Creative Commons Attribution 4.0 International License (CC BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are properly credited.</p> <p></p> <p>Scan the QR code for the Journal Homepage</p>	<p>This paper aimed at a newer technique for dorsal augmentation during rhinoplasty using diced cartilage wrapped in fascia. The usage of diced cartilage has been variously described in the literature with consistently satisfactory results. We present our early experience with patients undergoing dorsal augmentation during rhinoplasty using an updated method of diced cartilage wrapped in fascia with a single incision at donor site. The term is broadly descriptive and there remains a wide-range of ways to execute. Updating and enhancing the technique with greater attention to create precision, and creating an aesthetically optimal and predictable result, may improve outcomes for future patients.</p> <p>Keywords: Rhinoplasty, revision rhinoplasty, dorsal augmentation, costal cartilage, diced cartilage, DCF, diced cartilage fascia.</p>	
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INTRODUCTION

The history of dorsal augmentation during rhinoplasty emulates in many ways the progression of increasingly higher standards of care in medicine, driven by technological advances and rapidly evolving therapies. Early attempts were decidedly crude, with a wide assortment of everyday materials including ivory¹ and jade used to increase the height of the nose. Though the years, surgeons have attempted to improve outcomes by utilizing a variety of autologous and alloplastic materials, including cartilage, bone²⁻⁴, fascia, diced cartilage silicone, polytetrafluorethylene, and various type of incisions have also been used. All with mixed results⁵.

When many contemporary surgeons favor autologous grafts in an onlay configuration for mild to moderate amounts of dorsal augmentations^{2,6,10} on demand a larger volume of graft materials have prompted surgeons to explore alloplastic (silicone, Goretext, etc.) and homoplastic (irradiated costal cartilage) options. The use of Artificial implants can obviate the need for donor site incision and its morbidity²⁻⁵.

However, a primary downside of artificial implants can be a relatively high risk of complications compared to autologous graft techniques, driving some surgeons to pursue this avenue.

The use of diced cartilage in dorsal augmentation has been periodically documented in the English literature as early as 1943 by Peer, in 1951 by Cottle, and in 1968 by Burian, though it did not gain wide-spread acceptance at the time.⁶⁻⁷ Guerrerosantos revisited this concept in the 1990s⁸, refining the technique by wrapping fragmented cartilage in fascia, while Erol brought a larger audience with his description of wrapping diced cartilage in Surgicel in 2000⁹. Daniel subsequently brought a renewed interest in wrapping diced cartilage in fascia^{6,7}. Modifications of the concept of using diced cartilage as the building block for dorsal augmentation have been variously described, primarily adding assorted tissue adhesives to ease shaping of the graft, altering the material wrapping the cartilage or foregoing an encasement altogether^{9,10,11}. The manifold existing descriptions in the literature notwithstanding, a systematic approach refining the

surgical technique to achieve greater precision and consistency using diced cartilage with fascia has not been previously delineated.

Diced cartilage with facial harvest in a same incision represents a potentially ideal graft for dorsal augmentation, as it makes use of the lower complication rates associated with autologous grafts, while also providing a graft that has the ability to recreate dorsal aesthetic lines in a natural and predictable manner. The usage of diced cartilage has been variously described in the literature, with consistently satisfactory result. Herein, we present our early experience, with patients undergoing dorsal augmentation during rhinoplasty using an updated method of diced cartilage wrapped in fascia using a single incision at donor site.

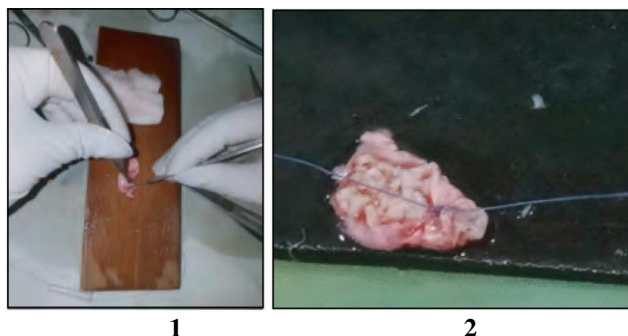


Figure 1: Conchal cartilage sliced into microdices

Figure 2: Microdiced cartilage being wrapped in retroauricular fascia

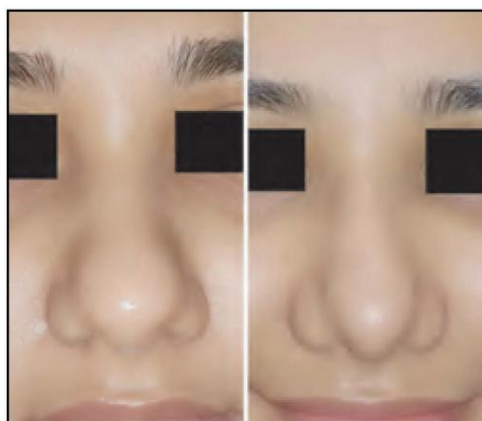


Figure 3: Before and after Microdiced Cartilage Fascia Augmentation Rhinoplasty -front view

MATERIALS & METHODS

Total of 3 patient were operated for nasal dorsal augmentation, during a period of 4 months from October 2019 to January 2020. All 3 patients were female; age range was 22 to 31 years.

Procedure

After proper assessment and under general anesthesia, conchal cartilage was harvested from the auricle using vertical incision posteriorly. After harvesting, the end of the incision was extended upward and backward into the scalp in a zigzag manner. Retroauricular fascia was then harvested. The length and width of the harvested fascia depended on the dimension of the cartilage graft. Hemostasis was ensured with diathermy. Closure was attained by 4/0 vicryl. By open rhinoplasty method dorsal tunnel was dissected along the midline. Lower alar cartilages (LAC) were trimmed and fibrofatty tissue debulking from the tip was done as required. The Conchal cartilage was sliced into microdices using a sharp blade. (Figure 1) The retroauricular fascia was spread out onto a wooden board and pinned at four corners. The microdiced cartilage was aligned vertically and the fascia wrapped around it. (Figure 2) The facial margins were then sutured by 4/0 vicryl. This diced cartilage fascia graft was then gently inserted in the dorsal tunnel. Necessary moulding was done to attain the desired shape. The LACs were apposed in the midline again using 4/0 vicryl. Wound closure was done with 6/0 prolene and 4/0 vicryl. Light nasal pack and malleable external splint was applied.

RESULTS

The results of all 3 patients were satisfactory and no complications were encountered. Since the follow-up period was small, further follow up is required for assessment of long-term results. (Figure 3)

DISCUSSION

Given the contemporary focus of minimizing complications and creating a sustainable result, many rhinoplasty surgeons have moved towards exclusively using autologous grafts during dorsal augmentation. Diced cartilage fascia techniques have proven fascinating due to its relative pliability, wide availability of materials needed for the construct, and the perceived forgiving nature with regards to contour irregularities¹².

Diced cartilage fascia techniques for dorsal augmentation in rhinoplasty and revision rhinoplasty have been variously utilized and described for over half a century. Although producing satisfactory result in many cases, at the same time has received criticism for creating a "sausage-like" appearance or an otherwise unnatural look to the dorsum. The term is broadly descriptive and there remains a wide-range of ways to execute it^{13,14,15}.

Contour irregularities as well as multiple incisions made for harvesting tissue remain the most common reason for surgeon and patient dissatisfaction after dorsal augmentation using diced cartilage with fascia. Sub-optimal contours may manifest in the form of convexities and concavities, over or under augmentation, deviation, asymmetries, and unnatural dorsal anesthetic lines.^{16,17,30} Conservative management of minor contour irregularities with nasal scar (especially within the first month following surgery), and directed injections of kenalog and 5-fluorouracil for scar management will successfully address many of the irregularities observed in the early post-operative period^{18,19,20}. Persistent contour irregularities beyond post-operative edema due to coalesced diced cartilage will infrequently warrant revision surgery.

CONCLUSION

This updated diced cartilage fascia technique with a single incision eliminates an additional donor site incisions and morbidity. It can enhance precision to create more predictable and consistently beautiful results^{23,24}. A further attention on precision approach for practicing the DCF graft may result in even improved outcomes for future patients^{25,26,27}.

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