



Confronting The Unexpected:- Saddle During Septal Surgery

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ABSTRACT

Septal surgery is aptly captioned the “bread and butter surgery”, of the ENT surgeon. Sometimes in this basic surgery the unexpected happens. A septal perforation or a saddle of the cartilaginous dorsum. The former lies hidden deep inside while the latter affects the facial profile and one becomes an object of ridicule. Utilising the resected tissue or tissues from nasal vicinity one can augment the depression.

In certain septal deformities, the inferior border of the quadrangular cartilage overrides the premaxillary and the maxillary crest, thereby producing a sharp or a blunt spur. Resection of the same with a “antero-posterior chondrotomy” attains a good nasal patency. A jutting premaxillary or maxillary crest is amenable to a similarly oriented “osteotomy”.

Keywords: Saddle Nose, Rhinoplasty, Septoplasty

Introduction

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Case Report

An 18 year old male underwent a septal surgery for a deviated septum where the inferior septal border and the anterior part of the ethmoidal plate, was resected. Though the nasal patency was attained but accentuation of the saddle on the cartilaginous dorsum was noticed. The cartilage resected from the quadrangular cartilage was refashioned and two segments, in a palisade arrangement, were positioned in a pocket created on the cartilaginous dorsum. A transcolumellar incision was given to gain access to the nasal dorsum. Dissection was limited to the midline to avoid a lateral displacement of the grafts. The larger graft was oriented with the convexity facing upwards and the small sized one in the arch of the former.

Discussion

Saddle nose deformity corresponds to loss of projection of the cartilaginous and/or bony structure of the dorsum of the nose, which has aesthetic as well as functional repercussions.

Although not so common, septoplasty carries the risk of inducing nasal deformity such as saddle nose and deviated nose. Surgical correction for these deformities is a formidable task to deal with, because the septal cartilage framework is already weakened due to the procedure.

The classification of saddle nose given by Durbec et al¹

Stage 1: minimal saddle nose

Minimal saddle nose corresponds to a depression above the supratip of the nose due to loss of septal support associated with slight retraction of the base of the columella, while tip projection and rotation are not affected.

Stage 2: moderate saddle nose

Moderate saddle nose corresponds to more marked recession of the dorsum, but not exceeding 5 mm. It induces loss of septal support that can affect its anatomical relations with the triangular cartilages, the tip or even the columella. The nose has a flattened appearance on all views. Decreased projection and/or cephalic rotation of the tip may be observed at this stage and will need to be taken into account.

Stage 3: major saddle nose

Major saddle nose corresponds to a marked lack of bony and cartilaginous support. The bony arch of the middle third of the nose is amputated inducing major retraction of the

**Fig. : 1****Fig. : 2****Fig. : 3**

nasal mucosa, while loss of the height of the cartilaginous septum is responsible for columellar retrusion. Tip projection is decreased and the nostrils are broader, giving a short nose appearance. Functionally, this deformity alters the internal (due to collapse of septal support) and external nasal valves (due to lack of central support, the nostrils become flatter and wider)

In our case it was minimal saddle nose which was corrected by restoring satisfactory septal height. We performed an extracorporeal rhinoplasty with excision of the nasal septum and constitution of a cartilaginous framework. This technique has been described for the management of a crooked nose ²which remains its main indication, but it can be adapted to minimal stages of saddle nose.

In this the defect can be corrected with sagittal projection and restoration of a harmonious and regular dorsum. Autologous graft from the septum associated with this

**Fig. : 4**

rhinoplasty help to restore a harmonious appearance of the middle third of the nose and correct the defect of the internal nasal valve. The base of the nose is tightened by means of the sagittal support of the cartilaginous framework. Other graft materials that can be used are autologous conchal cartilage and costal cartilage.

Due to the ease of harvestation and anatomical similarity in our case we preferred using the autologous septal cartilage.

CONCLUSION

Septoplasty is a routine otorhinological procedure with few complications like septal perforation, saddle nose due to excessive resection of the nasal septum. If recognised early during intraoperative interval, this can be corrected in the same sitting by using the autologous septal cartilage through a transcolumellar incision. This technique produces minimal scarring and adequately counters the saddle defect following the septal surgery.

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