Aesthetic Rhinoplasty as a Surface-Contour Operation: From Analysis to Surgery—Personal Concepts

Palma Pietro, MD, FACS1,2 Khodaei Iman, MD, FRCS3 Vasilenko Irina, MD, PhD, FACS4,5

1 The Milan Face Clinic, Milan, Italy
2 Department of Otorhinolaryngology Head and Neck Surgery, Hospital of the University of Insubria, Varese, Italy
3 Department of Ear, Nose & Throat, Chesterfield Royal Hospital, Chesterfield, United Kingdom
4 Department of Plastic & Reconstructive Surgery, Federal Center of Otorhinolaryngology, Moscow, Russia
5 Department of Plastic Surgery, Peoples’ Friendship University of Russia, Moscow, Russia

Address for correspondence Palma Pietro, MD, FACS, Department of Otorhinolaryngology Head and Neck Surgery, University of the University of Insubria, Viale Luigi Borri, 57, 21100 Varese, Italy (e-mail: mail@pietropalma.it).


Abstract

Numerous beautiful rhinoplasty results have been created by closed rhinoplasty techniques over the past 100 years. This operation was mainly a “reduction” surgery. Overaggressive reduction rhinoplasty is not a hallmark of the closed approach per se, but represents the result of inappropriate aesthetic appraisal, inadequate technical execution, or lack of sound anatomical understanding. Clearly, an operation based primarily on reduction intrinsically exposes the surgeon to the possibility of excessive diminution of support structures and consequently undesirable side effects. The advent of the external approach in the 1970s marked a paradigm shift. In the early 1990s, the external approach witnessed further development with the introduction of “structural rhinoplasty,” a deconstruction procedure followed by structural reconstruction. Opponents of the external approach felt that opening every nose can result in an overkill, specifically because the vast majority of patients presenting for cosmetic rhinoplasty neither desire nor require major reconstruction of the nose. In the last decade, the poorly named “closed” approach, once the pariah of rhinoplasty, has been rethought especially in the light of the undesirable long-term side effects, reappraised, and found a new lease of life as “endonasal rhinoplasty.” The personal surgical evolution of the senior author (P. P.) has created the concept of “hybrid endonasal rhinoplasty” (HER), where the term “hybrid” implies the incorporation of anatomical concepts and sophisticated suturing–grafting techniques developed by “openers” into the theoretical and technical corpus of HER. The senior author (P. P.) pondered over heterogenous concepts such as filling–reshaping, derived from the so-called medical rhinoplasty, and embodied these concepts into a purely surgical endonasal perspective. Consequently, aesthetic rhinoplasty can be considered a “surface-contour” operation. Nasal analysis, preoperative work-up, surgical logic, and operative techniques have been rethought. The patient is only interested in nasal appearance, not in its anatomy, so deconstructing the nose to change the subtle and demanding interplay of light and shadow is in many cases an overkill. Our emphasis should be on those structures that can be tackled and result in the ultimate aim of altering the aesthetic aspects of surface anatomy. Surface HER can deliver on all these counts.

Keywords
► rhinoplasty
► closed rhinoplasty
► endonasal rhinoplasty
► hybrid rhinoplasty
► surface-contour operation
Looking Back—Looking Ahead

The War of the Noses
Numerous beautiful rhinoplasty results have been created by closed rhinoplasty techniques over the past 100 years. This operation was mainly a “reduction” surgery. Reduction of the nasal framework still reflects the desires of many primary rhinoplasty patients. Clearly, an operation based primarily on reduction intrinsically exposes the surgeon to the possibility of excessive diminution of support structures and consequently undesirable side effects.

Overaggressive reduction rhinoplasty is not a hallmark of the closed approach per se, but represents the result of inappropriate aesthetic appraisal, inadequate technical execution, or lack of sound anatomical understanding.

The advent of the external approach in the 1970s marked a paradigm shift. Surgical anatomy became much more easily understood, working with binocular vision and both hands was more comfortable, rhinoplasty surgery could be more easily taught, excessive reduction could be more easily avoided, anatomical reconstruction was more precise, and several techniques of suturing grafting were developed.

In the early 1990s, the external approach witnessed further development with the introduction of “structural rhinoplasty,” a deconstruction procedure followed by structural reconstruction.

Opponents of the external approach felt that opening every nose can result in an overkill, specifically because the vast majority of patients presenting for cosmetic rhinoplasty neither desire nor require major reconstruction of the nose.

More recently, the external approach has evolved into newer and more conservative pastures: columellar struts are no longer deemed necessary in every case, shield grafts are recommended only in selected patients, the large-scale use of costal cartilage in primary rhinoplasty has shown a significant progressive decline, and even the systematic use of spreader grafts has come into question.

The war of the noses, nurtured by never-ending debates about the merits of one approach over the other, resulted in a dichotomy that irresolutely failed to reach consensus. Proponents of the external versus the closed approach provided excellent examples of successful rhinoplasty, with equally impressive selections of their opponent’s complications.

This divisive argument seemed endless with no end in sight or solid solutions. A moment’s reflection shows that personal choices on a specific approach are based on experience and allegiances rather than what is “right” or “wrong.” In truth, excellent results are possible no matter which approach we have been trained to use.

So do we need a happy medium, a compromise, a new chapter?

In the last decade, the poorly named “closed” approach, once the pariah of rhinoplasty, has been rethought especially in the light of the undesirable long-term side effects, reappraised, and found a new lease of life as “endonasal rhinoplasty.” Endonasal rhinoplasty is neither “closed” nor exclusively a reductive surgical operation. A nouvelle vague of endonasal rhinoplasty surgeons, who are more “shapers” than “reconstructors,” is progressively expanding and gaining worldwide reputation and enthusiastic consent from patients.

The personal surgical evolution of the senior author (P. P.) has created the concept of “hybrid endonasal rhinoplasty” (HER), where the term “hybrid” implies the incorporation of anatomical concepts and sophisticated suturing-grafting techniques developed by “openers” into the theoretical and technical corpus of HER.

The end result is a higher technical flexibility allowing a tailor-made procedure for each patient, while minimizing tissue trauma, unnecessary scarring, and tissue plane distortion. Technical evolution has made HER a technical option even for the most challenging patients, both in the primary and revision settings. In other words, the fundamental advantage of HER is that the patient’s anatomy dictates the surgeon’s technical choices, rather than the other way round.

Rhinoplasty, however, is much more than a technical challenge, and rhinoplasty surgeons should be ready to listen to and learn from their patients. Minimally invasive medical and surgical procedures have gained greater public acceptability.

For example, “medical rhinoplasty” has found great popularity and resulted in a decrease in plastic surgery practices. Specifically in rhinoplasty, we have witnessed a change in demography, tastes, demands, and expectations. Even the referral sources and the way of consulting cannot be compared with the recent past.

A critical question for the rhinoplasty surgeon, especially for those in private practice, is how to constantly meet the variable and evolving demands from patients. These reflections have brought the senior author (P. P.) to ponder over heterogenous concepts such as filling-reshaping, derived from the so-called medical rhinoplasty and to embody these concepts into a purely surgical endonasal perspective. Consequently, aesthetic rhinoplasty can be considered a “surface-contour” operation.

This paradigm shift in thinking requires further explanation.

Why Less Is (Often) More
In HER, the best techniques from both worlds (closed and external) are chosen to create a new, unifying concept. This has important implications for the preoperative phase of patient assessment, self-appraisal, and training of juniors. Deconstruction of the nose is not deemed necessary in most primary cases. This obviates the need for structural reconstruction and shortens the operative time. Grafts can be utilized judiciously and with due respect to their ability to absorb, warp, or move with time. Overreliance on sutures to force tissues into a particular shape is a haggard concept. Tip sutures are not a benign maneuver as they can lead to unforeseen problems such as malposition of the alar border, domes asymmetry, visible/palpable ridges, and recurvature of peridomal areas. In addition, the conglomerate of suture material with the surrounding scar tissue, along with microfractures of the cartilage weakened by sutures, makes revision surgery extremely difficult and hazardous.

The savvy rhinoplasty surgeon must remember that even the most skilled practitioner has a certain revision rate. Such
an inherent revision rate requires minimizing tissue trauma at the time of the primary surgery. Therefore, minimal tissue plane distortion, limited scarring, preservation of normal support structures, conservation of the maximal possible amount of septal cartilage, and faster healing make revision surgery much easier with HER.

From a patient’s aesthetic point of view, the surface anatomy of the nose is the most important aspect that requires change. The astute rhinoplasty surgeon will list the patient’s list of desires for surface change, create a tailor-made surgical game plan, and select adequate and effective rhinoplasty techniques to achieve these aims.

The real war of the noses is between the interplay of light and shadow in facial analysis and how minimally invasive surgery can restore harmony between the world of light and darkness. “Chiaroscuro” is an Italian term for the interplay between light and shadow. In the world of Renaissance art, “chiaroscuro” consists of using strong contrasts between light and darkness. It is also a technical term used by artists and art historians for the use of contrasts of light and shadow that achieves a sense of volume in modeling three-dimensional objects and figures.

The Tip of the Iceberg
Two decades ago, the “bi-tip” popularized by Dallas rhinoplasty courses was the gold standard in surgical teaching. This has been and probably remains the most common “ideal tip” in many rhinoplasty surgeons’ minds. However, experience demonstrates that a surgeon’s perspective is often at odds with patients’ desires. For varied and complex reasons, patient’s desires for tip aesthetics have changed. Surgeons must realize that they are not the instigators of public taste. The world of fashion, movies, and peer pressure in many rhinoplasty surgeons’ minds. However, experience demonstrates that a surgeon’s perspective is often at odds with patients’ desires. For varied and complex reasons, patient’s desires for tip aesthetics have changed. Surgeons must realize that they are not the instigators of public taste. The world of fashion, movies, and peer pressure in the world of light and darkness. “Chiaroscuro” is an Italian term for the interplay between light and shadow. In the world of Renaissance art, “chiaroscuro” consists of using strong contrasts between light and darkness. It is also a technical term used by artists and art historians for the use of contrasts of light and shadow that achieves a sense of volume in modeling three-dimensional objects and figures.

The real war of the noses is between the interplay of light and shadow in facial analysis and how minimally invasive surgery can restore harmony between the world of light and darkness. “Chiaroscuro” is an Italian term for the interplay between light and shadow. In the world of Renaissance art, “chiaroscuro” consists of using strong contrasts between light and darkness. It is also a technical term used by artists and art historians for the use of contrasts of light and shadow that achieves a sense of volume in modeling three-dimensional objects and figures.

Nasal Analysis Rethought—Thinking Like an Artist
Visual Analysis
Renaissance masters developed the concept of “chiaroscuro,” a balance between light and shadow that emphasizes the beautiful contrast of facial features. In surface analysis of the nose, both the chiaroscuro (on frontal view and three-fourth views) and the surface contours of the nose (on profile views) are taken into account with special emphasis on surgically modifiable landmarks.

Frontal View and Three-Fourth Views
These consist mainly of “chiaroscuro” (lights and shadow) analysis. There are four “chiaroscuro” border lines (two brow-tip lines and two nose-cheek lines) in the frontal view, which demarcate three areas: a central “bridge light” and two bilateral sidewall shadows.

The four surface aesthetic subunits of the nasal tip: central (domal) light, lateral (alar) light, supra-alar shade, and scroll shade (Fig. 2).

The Tip of the Iceberg
Two decades ago, the “bi-tip” popularized by Dallas rhinoplasty courses was the gold standard in surgical teaching. This has been and probably remains the most common “ideal tip” in many rhinoplasty surgeons’ minds. However, experience demonstrates that a surgeon’s perspective is often at odds with patients’ desires. For varied and complex reasons, patient’s desires for tip aesthetics have changed. Surgeons must realize that they are not the instigators of public taste. The world of fashion, movies, and peer pressure in the world of light and darkness. “Chiaroscuro” is an Italian term for the interplay between light and shadow. In the world of Renaissance art, “chiaroscuro” consists of using strong contrasts between light and darkness. It is also a technical term used by artists and art historians for the use of contrasts of light and shadow that achieves a sense of volume in modeling three-dimensional objects and figures.

The real war of the noses is between the interplay of light and shadow in facial analysis and how minimally invasive surgery can restore harmony between the world of light and darkness. “Chiaroscuro” is an Italian term for the interplay between light and shadow. In the world of Renaissance art, “chiaroscuro” consists of using strong contrasts between light and darkness. It is also a technical term used by artists and art historians for the use of contrasts of light and shadow that achieves a sense of volume in modeling three-dimensional objects and figures.

The real war of the noses is between the interplay of light and shadow in facial analysis and how minimally invasive surgery can restore harmony between the world of light and darkness. “Chiaroscuro” is an Italian term for the interplay between light and shadow. In the world of Renaissance art, “chiaroscuro” consists of using strong contrasts between light and darkness. It is also a technical term used by artists and art historians for the use of contrasts of light and shadow that achieves a sense of volume in modeling three-dimensional objects and figures.

The real war of the noses is between the interplay of light and shadow in facial analysis and how minimally invasive surgery can restore harmony between the world of light and darkness. “Chiaroscuro” is an Italian term for the interplay between light and shadow. In the world of Renaissance art, “chiaroscuro” consists of using strong contrasts between light and darkness. It is also a technical term used by artists and art historians for the use of contrasts of light and shadow that achieves a sense of volume in modeling three-dimensional objects and figures.
Regarding the aesthetic evaluation of the tip on the profile view, classically, the tip is analyzed in terms of the so-called extrinsic factors: rotation and projection. In this classical description, there is no mention of the length of the nose. The nasal length (NL) is a highly relevant surgical parameter that requires specific surgical attention. We consider NL as the distance between the Na and the most caudal point of the columellar contour.

In the authors' view, the key surface-contour parameter of the tip on the profile view is represented by tip position (TP), which results from the interaction of three parameters (rotation, projection, and length). These three parameters are different in each patient. Therefore, every individual patient's nose demands careful, individualized preoperative analysis and tailor-made surgical planning.

TP is measured by three different angles: tip angle, nasolabial angle, and columellar-labial angle (CLA). It is crucial to evaluate each of these three angles as they are related to different anatomical structures: position of the Pr, inclination of nostril axis, columellar shape, maxilla/premaxilla development, and upper lip position. It is vitally important to fully understand the difference among these three angles to precisely address the anatomical structure(s) responsible for that/those specific defect(s) to be corrected.

Regarding the surface-contour analysis of the tip-lip junction, we consider:

**Fig. 3** Surface-contour landmarks of the nasal dorsum: nasion (Na), rhinion (Rh), supratip break point (SBP), and pronasale (Pr).

**Fig. 4** The profile three aesthetic subunits (PASUs) of the nasal profile: PASU 1, from Na to Rh; PASU 2, from Rh to SBP; and PASU 3, from SBP to Pr.
Contour landmarks: SBP, Pr, infratip break point (IBP), and subnasale (Sn) (Fig. 5).

These four contour landmarks define three tip-lip aesthetic subunits (TLASUs): TLASU 1, from SBP to Pr; TLASU 2, from Pr to IBP; and TLASU 3, from IBP to Sn (Fig. 6).

Noncontour landmarks: nostril orientation axis, alar rim position, nostril apex, and columellar show (Fig. 7).

The tip-lip junction represents one of the most significant elements of a good aesthetic outcome. One of the aesthetic problems we see in the post-open rhinoplasty patients is represented by the less-than-ideal shape of the columellar contour: in most of the cases, it appears straight rather than displaying a gentle curvature, in addition to a rough transition between the three TLASUs.

Base View

From the surface analysis point of view, in the base view, we distinguish:

- Contour landmarks: SBP, Pr, infratip break point (IBP), and subnasale (Sn) (Fig. 5).

These four contour landmarks define three tip-lip aesthetic subunits (TLASUs): TLASU 1, from SBP to Pr; TLASU 2, from Pr to IBP; and TLASU 3, from IBP to Sn (Fig. 6).

- Noncontour landmarks: nostril orientation axis, alar rim position, nostril apex, and columellar show (Fig. 7).

The external approach can lead to problems such as round nostrils, different heights of the nostril apex, pinching of the nostril apex, retraction, or eradication of the soft triangle. Aesthetically, these less-than-ideal side effects are very hard or impossible to correct.

Tactile Analysis

Systematic palpation of the nose in its entirety represents a precious source of information for the rhinoplasty surgeon. Thickness, texture, and elasticity of the skin soft tissue envelope need to be carefully evaluated as these parameters have a direct effect on both the choice of surgical technique and the surgical outcome. Fingertips can palpate the size, shape, and firmness of the structural framework. Special attention should be reserved for junctional areas between the bony and cartilaginous framework, both centrally and laterally. Finger pressure above the tip shows the position of the domes and their symmetry, as well as the dynamic relationship between the tip and the anterior septal angle. Cephalic borders of the lower lateral cartilages should be located by gentle elevation of the nasal tip. Lower lateral cartilages should be palpated carefully so as to define size, strength, and orientation. The “tip recoil test,” that is, pushing...
the tip down and then immediately releasing it, reveals the degree of tip support. By placing the tip of the thumb in one vestibule and the tip of the index finger into the other, the surgeon can assess the position, thickness, shape, and mobility of the caudal septum. This technique will also allow the surgeon to feel the characteristics of the membranous septum by pulling on it. By palpating the nasal spine, information is collected about its shape, symmetry, and protrusion.

Photoanalysis
Analysis of the patient’s facial/nasal photographs is essential in surgical planning as it enables the surgeon to assess problems that may have been missed in the initial anatomical examination. Photoanalysis is also necessary for discussing surgical options with the patient. One author (P. P.) systematically uses a set of 14 standard views: two frontal (static and dynamic) views, two profile views, four three-quarters views (two per each side), one base view, one helicopter view, two “base-radix” views, and two dynamic lateral views. The study of symmetry is also performed in every single case.

One author (P. P.) builds up two virtual noses: the first by opposing the two right halves along the midline, and the same is then done for the two left halves. We prefer not to rely on numerical data but discuss the general impression of symmetry or crookedness and highlight the role of the nose in this perception. Rhinoplasty is almost always an asymmetrical operation, thus requiring asymmetrical surgery.

Vertical and horizontal lines have been used to divide the human face into thirds and fifths. Although this tool is useful for a general inspection of the face, its relevance to contemporary facial analysis has come into question from a clinical point of view. For instance, authors use the intercaruncular distance (ICD) as the reference distance to evaluate the alar base width in their Mediterranean patients as ICD better fits the overall aesthetic proportion of the Mediterranean/Middle East faces, instead of the classical intercanthal distance, which does better match Northern European faces.

Due to the significant movement of people in the last two centuries, and the emergence of transcontinental travel, terms such as “ethnic nose” have come into question as there is a definite move toward global, unified facial aesthetics, especially among millennials.

From a practical point of view, the authors employ the light-shadow interplay as a clinical aid to decipher the surface anatomy of the nose and its surrounding structures.
Finalizing the Preoperative Work-Up

Following a thorough history with particular attention to the patient’s wish list for change, physical examination, nasendoscopy, and photoanalysis, the surgeon creates a list of surgically modifiable landmarks. The space between the first and second consultation creates much needed thinking time for both the patient and the surgeon. During the second consultation, the surgeon reports on the findings, fine-tunes the surgical plans, and creates a detailed, individualized, tailor-made game plan for that patient. The same operation is never repeated for another patient.

The Logic Behind the Surgery

Key questions for the surgeon to consider include the patient’s desires, and their achievability and reasonableness. As there is no cookie cutter approach to rhinoplasty, the game plan for each patient’s problems has to be uniquely designed for each case.

Endonasal approaches include the following:

- Transcartilaginous, first-level approach: aimed at changing slight derangements of intrinsic tip parameters.
- Transcartilaginous extended, second-level approach: aimed at changing moderate-degree derangements of intrinsic and extrinsic tip parameters.
- Delivery, for complex tip: the term “complex” is in relation to both anatomical complexity, and surgeon’s skills and dexterity.
- Infracartilaginous, partial (“slot” incision) or complete, when limited or extensive tip plasty, only is to be performed without dorsum surgery.
- Mixed, when the approach is different on the two sides depending on the specific anatomy of the patient.

Surgery (including osteotomies) is planned based on surface aesthetics. Preoperative drawing on the external nasal skin is paramount and is done immediately before surgery, with patient awake and standing.

The nasal dorsum is never infiltrated as we prefer to keep the constant palpatory feedback of the dorsal modification (WYSIWYG principle: What You See Is What You Get).

The subdivision of profile contour and tip-lip contour into aesthetic subunits allows the surgeon to make a precise aesthetic analysis on the topography of the defect and therefore identify the surgical target precisely.

The goal of the surgical planning is to identify the aesthetic subunits to be restored and to determine modifiable landmarks (charoscutro and contour landmarks) on all the different patient’s views. Essentially, the aesthetic goals are represented by both highlighting the aesthetic landmarks (charoscutro and contour landmarks) and attenuating the blending of the junctional areas among the subunits of both dorsum and tip-lip junction.

Surgery—My Way

Tip Surgery

Favorite Sutures

- Modified “tongue-in-groove” technique: through a hemitransfixion incision, a columellar pocket is created in between the medial crura to create space for placement of the caudal septum. Shape and length of the caudal septum are adjusted to reach the desired columellar length/shape. The vestibular lining is bilaterally trimmed according to the new shape/length of the caudal septum. At the end of the procedure (without placing any columellar strut), the septum will be fixed into the columellar pocket through three or four mattress septocolumellar sutures using an absorbable monofilament. This “modified tongue-in-groove” technique can be used to stabilize the tip, to reduce NL and excess of columellar show, and to finely reshape aperture of the CLA and contour of the tip-lip junction.

- Subdomal suture: after creating a dissection plane through the paired medial crura through the hemitransfixion incision, the superior parts of the medial crura are stretched using a Cottle forceps and secured in the new position by a double mattress suture with a straight monofilament.

Fig. 9 (A–D) Gender-specific surface landmarks contour on the frontal view.
needle. This reduces the angle of the domal width by approximating the superior parts of the medial crura.

- Dome-defining suture, that is, the transdomal suture.
- Wonderbra suture: it is a mattress septocolumellar suture made with a straight monofilament needle. The passage on the septal aspect of the suture is done at a different level than the one through the columellar aspect. This suture allows slight overrotation or underrotation of the nasal tip.
- Basicolumellar suture: the base of the columella, when wide or asymmetrical, can be narrowed or made more symmetrical by removing the soft tissues, through the hemitransfixion incision, in between the feet of the medial crura, which are then approximated by a mattress suture made with a straight monofilament needle.

Favorite Grafts

- Domes onlay (through "slot" infracartilaginous incision or classical delivery).
- Alar batten (through infracartilaginous incision or classical delivery).
- Rim graft (through "slot" infracartilaginous incision).
- Facet graft (through "slot" infracartilaginous incision).
- Columellar strut graft (used by the authors with greatly diminishing popularity in the past few years as the modified tongue-in-groove works better and avoids the drawbacks of the strut, such as clicking and displacement, felt at palpation).
- Plumping graft (through hemitransfixion incision or “slot” infracartilaginous incision). This graft is very useful to modify the area of and around the Sn.
- Septal extension graft (through hemitransfixion incision).
Rhinoplasty surgeons should be aware that they deal with two different profiles: the clinical profile (which is the surface profile) and the framework profile (the boney-cartilaginous profile). They are not parallel as the superficial muscular aponeurotic system (SMAS) of each patient creates a difference between the clinical and framework profiles, hence the irreplaceable importance of nasal palpation.

Profile Surgery

Fig. 13  (A,C,E,G,I,K,M,O,Q) Preoperative views. (B,D,F,H,J,L,N,P,R) Postoperative views. Young female patient complaining about nasal hump, large tip, and tip animation as the main aesthetic concerns. Surface "chiaroscuro" landmarks on the frontal view and surface-contour landmarks on the side views have been restored. Contour and content of the base view have been addressed functionally and aesthetically.
In authors’ practice, the most common subjective complaint regarding profile is represented by the hump. In overprojected noses, profileplasty is the aim of the operation, rather than a simple humpexcision. Profileplasty means that the proper identification of the PASUs will guide the sequence of the operation. This is achieved in the following sequence: setting the Pr, followed by the radix, and, finally, the Rh.

Rhinoplasty surgeons should be aware of the gender-specific surface landmarks contour on the frontal view (Fig. 9A–D), as well as contour landmarks and profile views (Fig. 10A–D).

Fig. 14 (A,C,E,G,I,K,M,O,Q) Preoperative views. (B,D,F,H,J,L,N,P,R) Post-operative views. Secondary rhinoplasty patient complaining about polly tip as the main aesthetic concern. Revision surgery addressed contour and noncontour landmarks of the tip-lip junction, and the three profile aesthetic subunits of the nasal profile.
However, contour landmarks are to be set according to patients' wishes (Figs. 11A–D and 12A, B). Specialist counseling of the surgeon should be always given to the patient when patient's desires do not match the surgeon's aesthetic eye. Reaching a precise and written agreement before surgery (to be specified in the consent form) represents an absolute sine qua non.

The creation of a gender-specific profile is especially important in transgender rhinoplasty.

**Osteotomies**

According to the traditional teaching, osteotomies are aimed at closing the open roof, straightening bones, and narrowing a wide bony base. The most commonly taught osteotomies are represented by basal and paramedian curved osteotomies. The combination of basal and paramedian curved osteotomies does not provide valuable solutions, according to authors' experience, in common conditions such as an excessive width of unilateral/bilateral sidewalls, washed-out appearance of the upper and middle thirds of the external nose, and asymmetry of the upper and middle thirds of the external nose.

In aesthetic rhinoplasty, the interplay of light and shadow (chiaroscuro) is what defines the outcome from the patient's point of view. Therefore, osteotomy design is practically different in each patient.

Osteotomies pathways are planned on surface aesthetics, traced on the external skin, and executed with fine and well-sharpened osteotomes, often requiring multiple lines of fracture (intermediate osteotomies). Authors have almost abandoned paramedian curved osteotomies as they have minimal impact, if any, on aesthetic restoring of the surface anatomy and can result in a profound destabilizing effect on the bony-cartilaginous junction at the Rh area. Furthermore, they make dorsal rasing for dorsal refinement after osteotomies a highly risky maneuver. In authors' view, they have more drawbacks than advantages.

Osteotomies are key manoeuvres in recreating a highly individual light-shadow interplay unique to each individual.

**Fine Touches**

Often, subtle changes require micrografting (autologous cartilage flakes, mature scar tissue, or tragal/conchal cartilage) and gentle zonal defatting of the SMAS of the inferior nasal third. These refining techniques often make the difference between an ordinary result and a superlative one.

**Results**

As surface anatomy does not necessarily reflect the bony-cartilaginous framework beneath, deconstructing the nose to change the subtle and demanding interplay of light and shadow is in many cases an overkill. The patient is only interested in nasal appearance, not in its anatomy, so why do we seem obsessed with altering the major anatomical framework?

Our emphasis should be on those structures that can be tackled and result in the ultimate aim of altering the aesthetic aspects of surface anatomy.

Sometimes, this requires framework adjustment, and in many others, altering the entire foundations of the building just to create a more appealing color paint on the walls is excessive. Subtle but definite change is the key to a successful outcome. For many patients, the surgical game plan must result in asymmetrical changes to achieve maximal symmetry. Patients want faster recovery times, a natural, nonoperated look, and less costly surgery.

Surface hybrid rhinoplasty can deliver on all these counts (Figs. 13 and 14).

**Conclusions**

The war of the noses is over. The age of the standard "closed" or reductive rhinoplasty has almost expired and belongs to the last century. Patients' demand has changed rhinoplasty aesthetic aims and forces rhinoplasty surgeons to enter into less structurally aggressive rhinoplasty.

The true essence of aesthetic rhinoplasty aims at recontouring the surface of the nose, not altering the bowels of the earth. Unique rhinoplasty for each individual is a multistep, time-consuming, preoperative assessment pathway that requires patience and a long learning curve. The techniques used in surface HER are marked by their precision, reversibility, conservative tissue handling, and asymmetry of approach.

Self-assessment is the key to continuous improvement in results.

Contemporary endonasal rhinoplasty is a young surgical practice that requires aesthetic eyes, artistic manual skills, lifelong dedication, and unceasing reeducation. Rhinoplasty still continues to be “the thinking surgeon's operation” as defined by Jack Anderson, one of the greatest rhinoplasty legends.

**References**


Dayan S, Kanodia R. Has the pendulum swung too far?: trends in the teaching of endonasal rhinoplasty Arch Facial Plast Surg 2009;11(6):414–416


