SEPTOPLASTY

INDICATIONS FOR SEPTOPLASTY

- Nasal obstruction, crusting, rhinorrhea, post-nasal discharge, recurrent sinus pressure or pain, epistaxis, headache, snoring and sleep apnoea are mentioned as indications for septoplasty.

6 phases of surgical procedure:

1. Gaining access to septum
2. Correcting pathology
3. Removal of pathology
4. Shaping removed cartilage or bone
5. Reconstruction of septum
6. Stabilizing the septum

GAINING ACCESS TO THE SEPTUM

3. INCISIONS

Kilian’s Incision ➔ 2 to 3mm posterior to mucocutaneous junction

Hagek’s Incision ➔ at mucocutaneous junction

Freer’s Incision ➔ caudal end of septum (cuts through highly vascular area in membranous septum, easy access to nasal spine and premaxillary crest, least tendency for perf, easy access to caudal dislocation)

- Hemi transfixion is the basic incision used to gain access to the septum. In contrast to transfixion, the incision is not made in the membranous septum but over the cartilaginous septum parallel to the caudal edge, approximately 2 mm posterior to the edge.
- Anterior tunnel made between cartilage and perichondrium
- Inferior tunnels made
- In making the inferior tunnels, there is a posterior and an anterior approach.
- The latter is called the maxilla-premaxilla approach. It is more complicated and risks damage to the incisive nerve.
- However, it has the advantage that it can be used in cases where it is difficult to make an anterior tunnel.
- After tunnelling, the inferior part of the septum can be detached from the anterior nasal spine, premaxilla and the maxillary crest.
- Next an incision between the posterior part of the septal cartilage and the bony septum can be made. This is called a ‘posterior chondrotomy’.
- After these two procedures, the septum can be moved aside, rather like a swinging door. This swinging-door technique gives access to the posterior or bony septum.
CORRECTION OF SEPTAL PATHOLOGY

- Removing an inferior cartilaginous strip.

REMOVING SEPTAL PATHOLOGY

- More severe deformities require resection of parts of the septum and sometimes of the septal cartilage as a whole.
- After that, the resected area should be reconstructed preferably with the autologous materials already removed.
- When these are not available, the patient's ear or rib cartilage might be an alternative.

RESHAPING CARTILAGE AND BONE

- Cartilage does not heal. Fractures and defects will be filled up by connective tissue.

RECONSTRUCTION OF THE SEPTUM

- Only the patient's own septal cartilage meets the requirements for optimum reconstruction
- Ear or rib cartilage can be used as a substitute, but are second choice.

STABILIZING THE SEPTUM

- First of all, a dressing is put into the nose to bring the mucosa together.
- Mattress sutures have the same effect.
- Splinting by so-called nasal splints is effective in stabilizing reconstructions that are more extensive.