Preface

The nose is a distinctive facial feature of immense aesthetic importance in the center of the face. Attention focuses on the eyes in an attractive human face but quickly diverts to an unattractive or unnaturally shaped nose. To achieve optimal facial beauty, therefore, the nose must fit harmoniously and inconspicuously into the face. The nose is important to more than facial beauty, however; it is also an important sensory organ vital to one of the essential functions of life: breathing. For this reason, the significance of the nose has been respected in all cultures since ancient times—its amputation has long been used as a severe form of both physical and psychological punishments.

The ultimate objective of aesthetic rhinoplasty is to create a harmonious and natural-appearing nose that assimilates into the surrounding face with no visible signs of previous surgery. Of course, the functional aspects must also be respected, and the patient needs to be able to breathe comfortably and without restriction. Only then can the surgical result be considered a success.

In the early years of aesthetic rhinoplasty, nasal reduction procedures were the first improvements patients sought. In all probability, the German surgeon Dieffenbach performed the first nose reduction, employing a direct surgical approach in which he incised the whole dorsum to reduce the underlying skeletal framework. He was the successor to Ferdinand von Graefe who first started nasal reconstruction at a university clinic in Europe. Even though the first closed rhinoplasty was performed by Rowe who published this operation in 1887 in New York, in 1898 Jacques Joseph—today accepted as the godfather of rhinoplasty on both sides of the Atlantic—performed the first total nasal reduction, not knowing about his colleague’s prior operation in North America. Although these colleagues were unaware of Dieffenbach’s operation in 1845, in the more than 100-year history of standardized rhinoplasty, this procedure has become the most common surgical procedure in aesthetic surgery. Further, while a successful rhinoplasty may have enormous beneficial impact, every surgeon must be aware that a failed rhinoplasty leaves the patient with a facial deformity that cannot be concealed. For this reason, every rhinoplasty surgeon bears an enormous responsibility for the psychosocial well-being of the patient.

Unfortunately, there are now many surgeons who lack sufficient training or experience in this challenging field and who perform cosmetic nasal surgery primarily for economic gain. In 2009, rhinoplasty was the number one aesthetic operation in men. Nearly 70,000 men in the United States underwent the operation. In women, rhinoplasty was the second-most common aesthetic procedure after breast augmentation. Nearly 180,000 American women had their noses changed by this surgical procedure. The same tendency can be seen in Europe and elsewhere. It is therefore not surprising that of all aesthetic procedures, rhinoplasty has one of the highest rates of patient dissatisfaction. Indeed, according to the recent medical literature, rhinoplasty failure rates are estimated at 30%, and future increases are likely.

There are already many books, some of them excellent, on the market. However, only a limited number of rhinoplasty textbooks deal with secondary rhinoplasty. Presently, complex secondary rhinoplasty accounts for approximately 50% of my practice, and the demand for revision rhinoplasty is increasing worldwide. A greater understanding of the complex nuances of revision rhinoplasty is needed.

I have been operating on noses since 1976. With my medical background—double-boarded in plastic surgery and ENT—I am highly specialized in the field of rhinoplasty.

In 1980, I performed the first extracorporeal septal reconstruction, developing this technique into a standard procedure for the severely deformed septum. Over a period of about 20 years, I used the closed approach for extracorporeal septoplasty, which I had recommended for much of my early career. For this reason, I was invited to several meetings, where there was always considerable emphasis and controversy regarding the preference for the open versus closed rhinoplasty approach. Although I was always invited as a representative of the closed approach, thanks to these many discussions I slowly began to appreciate arguments in favor of the open approach. Ultimately, it was the influence of Gilbert Aiach, the famous French rhinoplasty surgeon, that prompted a complete change of mind in this regard. Now we too almost exclusively use the open approach. This procedure is more precise with regard to both the
analysis and the surgical procedure itself, and it helps to avoid problems that commonly arise with the closed technique, such as an unexpected drooping of the tip. Furthermore, precision increases safety and enhances quality. I personally think that the open rhinoplasty approach prevents numerous complications that would otherwise require revision surgery.

Furthermore, the open surgical approach enables us to perform many other useful rhinoplasty techniques with greater accuracy, such as the sliding technique (which we published in 2004) or the spreader flap technique for widening the inner valve. Although the spreader flap technique can also be used in a closed technique, as with the extracorporeal septoplasty, the closed approach is much less predictable and less reproducible relative to the open approach.

Finally, for many years, colleagues from all over the world who attended our Stuttgart courses on functional and aesthetic rhinoplasty have been encouraging me to publish our experience in this challenging and complex field. So finally I present this atlas, with a view to sharing our techniques and to helping all interested colleagues master the ever-challenging demands of secondary rhinoplasty.

I would like to express my sincere thanks to Rollin Daniel who encouraged me to start this project and who greatly supported me in achieving this goal. Furthermore, I am extremely grateful to Rick Davis for translating my Suebian English into an understandable American one without his support and help this book would not have been published.

My deep thanks go to Helmut Fischer who wrote chapters 3 and 4. He has been working with me for many years and stimulated me with a lot of new ideas. I am very grateful for the regular discussions about rhinoplasty problems with him, which increased the level of our work a lot!

Last but not least, I want to thank the many patients who graciously permitted use of their clinical photographs for publication in this rhinoplasty atlas. Because of their generous support, readers will undoubtedly gain a much clearer understanding of this challenging and often vexing operation. I will always be grateful for their selfless and valuable contribution.

Wolfgang Gubisch
Stuttgart, Germany
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Gubisch, W.
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