Corrective Rhinoplasty with Combined Use of Autogenous Auricular Cartilage and Porcine Dermal Collagen in Cleft Lip Nose Deformity

Young-Wook Park
Department of Oral and Maxillofacial Surgery, College of Dentistry, Gangneung-Wonju National University

Abstract

Esthetic reconstruction of cleft lip nose deformity is a challenging task in surgical management of patients with orofacial cleft. The author reconstructed cleft lip nose deformity effectively using autogenous auricular cartilage and a relatively new graft material of porcine dermal collagen, Permacol™. After correction of the deformed lower third of the nose with patient’s auricular cartilage, we applied Permacol™ to augment the entire nasal dorsum. Three patients were treated and followed for up to five years. All patients improved in nose aesthetics without any inflammatory or immunogenic reaction. The author suggests that the use of Permacol™ for nasal profile augmentation in the treatment of cleft lip nose deformity is an alternative surgical strategy with minimal surgical invasiveness. The author report long-term experience with combined use of auricular cartilage and Permacol™ in nasal reconstruction for cleft lip nose deformity.

Key words: Cleft lip nose deformity, Corrective rhinoplasty, Auricular cartilage, Porcine dermal collagen

Introduction

The nose is a central structure of the face, so attempts to reconstruct ideal form and esthetics can be complicated. The majority of patients with cleft lip nose deformity require augmentation rhinoplasty for a more balanced nasal dorsum. Traditionally, autogenous cartilages from various sites are used to correct cleft lip nose deformity. However, sometimes results of corrective rhinoplasty using auricular or septal cartilages are unsatisfactory due to the weakness of the graft material. In that case, rib cartilage could be a good material of choice for corrective rhinoplasty for cleft lip nasal deformity[1]. However, the harvesting procedure leaves a cutaneous scar that is unacceptable, especially for a young female patient. So we need to find alternative surgical options to replace the autogenous rib cartilage.

In 1998, a new biomaterial called Permacol™ (Tissue Science Laboratories plc, Aldershot, UK) was licensed in Europe for permanent implantation in human body. Permacol™ consists of acellular, cross-linked porcine dermal collagen that is resistant to degradation by collagenase. Furthermore, its structure is similar to that of human dermis. It had been widely used in general and gyneco-
logical surgery in the treatment of hernia[2,3] and otolar-
yngology surgery such as surgical closure of nasal septal perforation[4]. Recently it was described in facial contour augmentation surgery including esthetic augmentation rhinoplasty[5] and reconstruction of a post-traumatic nasal de-
formity[6].

The author augmented nasal dorsum after reconstruction of the lower third of the nose during corrective rhinoplasty in patients with cleft lip nasal deformity. In this report we describe three cases of rhinoplasty procedures using autogenous auricular cartilage and synthetic porcine der-
mal collagen with highlights of how to use it.

Case Report

1. Case 1

A 17-year-old female patient with secondary deformity due to unilateral incomplete cleft lip and palate was re-
ferred to the Department of Oral and Maxillofacial Surgery, Gangneung-Wonju National University Dental Hospital. Five years ago, she underwent autogenous bone graft on her cleft alveolus. During this time, her chief complaint was the deformed nose, so we decided upon corrective rhinoplasty and minor revision surgery on her upper vermilion. After taking standard rhinoplasty photograms, formal consent for the use of xenograft material was obtained.

The operation was performed under general anesthesia with additional anesthetics consisting of 2% lidocaine and 1:100,000 epinephrine in the planned dissection area. Via an open rhinoplasty approach with intercartilaginous and stair-shaped transcolumnellar incision (Fig. 1A), the lower lateral cartilage was dissected from surrounding soft tissues and prepared a subperiosteal pocket for the xenograft on nasal bone (Fig. 1B). After harvesting auricular cartilage from right ear (Fig. 1C), we applied it as a columellar strut (Fig. 1D) and cap graft (Fig. 1E) for a prominent nasal dome. The Permacol™ sheet comes ready to use and can be cut to the desired size easily. We inserted two layers (3 mm) of Permacol™ under the dorsal skin of the nose, and fixed it to the underlying cartilages with 4-0 polydioxanone (Fig. 1F). The upper portion of the Permacol™ was engaged in the prepared subperiosteal

Fig. 1. Surgical procedures performed on a 17-year-old female with nasal deformity from a unilateral incomplete cleft (case 1). (A) Surgical markings for planned position of Permacol™ and stair-shaped transcolumnellar incision. (B) Perichondral and subperiosteal dissection was performed to the root of nasal bone. (C) Auricular cartilage was harvested from the auricle of right ear. (D) Left lower lateral cartilage was sutured with a cartilaginous strut at its elevated position. (E) Excess auricular cartilage was used for cap graft for shaping the nasal tip. (F) After positioning of a two-layered Permacol™ sheet, cap graft was fixed with polydioxanone.
pocket. After closing the surgical wounds, we applied external nasal stent and tape for two weeks, as well as a nasal conformer for six months at night postoperatively.

Esthetic results in visits at one month, six months, and one year were satisfactory for patients and surgeon (Fig. 2). The dorsal implant was intact and did not show any resorption or displacement.

2. Case 2

A 17-year-old male patient with secondary deformity due to unilateral complete cleft lip and palate was referred to our department. He had undergone several surgeries including distraction osteogenesis for collapsed maxilla, secondary alveolar bone grafting for cleft alveolus, and pharyngoplasty by the author. On this occasion (January 25, 2009), corrective rhinoplasty was performed.

Under general anesthesia, open rhinoplasty was performed via an intercartilagenous incision, continuous with the transcolumnellar incision on the line of previous scar (Fig. 3A, 3B). After harvesting auricular cartilage from right ear (Fig. 3C), we applied it as a columellar strut and gull-wing type graft (Fig. 3D) to strengthen nasal tip support. We then implanted two layers of Permacol™ (Fig. 3E), and fixed it to the grafted cartilages with monocryl (Fig. 3F). After layered suture for wound closure, we applied an external nasal stent. Aesthetic results in follow-up visits were acceptable for the patient (Fig. 4).

3. Case 3

A 14-year-old male patient with secondary deformity due to bilateral cleft of primary palate presented to the department. His mother’s chief complaint was the visible scar on upper vermilion and the compressed nose, so we decided to perform a cheilorhinoplasty.

Under general anesthesia, open rhinoplasty was done via an intercartilagenous incision inside both nostrils and the incision for scar revision (Fig. 5A). After harvesting auricular cartilage from both ears, we applied it as a columellar strut and gull-wing type graft for prominent nasal dome (Fig. 5B, 5C). We then implanted two layers of Permacol™ in the form of an onlay graft, and fixed it to the grafted auricular cartilages with monocryl sutures (Fig. 5D, 5E). Good cosmetic results were obtained without any complications (Fig. 6).

Fig. 2. Preoperative (upper panel) and postoperative (lower panel) photographs of case 1.
Discussion

There is a vast number of surgical techniques and grafting materials for cleft lip nose deformity reconstruction. In general, autogenous tissues remain the gold standard for reconstructive surgery of cleft lip nose deformity. Especially for augmentation of the nasal dorsum, autogenous septal cartilage could be the material of choice[7]. However, autogenous grafting procedures require additional surgery and donor site morbidity, and sometimes graft material is limited. Thus maxillofacial plastic and reconstructive surgeons always need to prepare allogeneic or alloplastic materials as an alternative.

Silicone[8], high-density porous polyethylene[9], expanded polytetrafluoroethylene[10], and human dermal collagen[11] are used as alloplastic materials for augmentation rhinoplasty, and have both advantages and disadvantages. Permacol™ can be a useful material for augmentation rhinoplasty because it is readily available in the required volume, it is easy to shape, and it seems to main-
Fig. 5. Surgical procedures performed on a 14-year-old male with nasal deformity from a bilateral cleft (case 3). (A) Surgical markings for planned position of Permacol™ and incisions for open rhinoplasty. (B) Shaping of the harvested auricular cartilage. (C) Fixation of the auricular cartilage to the medial crus of the lower lateral cartilages. (D) Prepared Permacol™. (E) Permacol™ xenograft was fixed with polydioxanone.

Fig. 6. Preoperative and postoperative frontal (A) and lateral (B) photographs of case 3.

tain the structural integrity of the nose.

In this study, three patients underwent corrective rhinoplasty via external approach using autogenous auricular cartilage and Permacol™ composite grafting. The original dimension of the Permacol™ sheet used was 60×30×1.5 mm, and two layers of Permacol™ were inserted into the nasal dome with customized size for each patient. If layering is required, the material can be cut into separate sheets, creating edges rather than folding or rolling, probably due to possible colonization of microorganisms. The flexible sheet immediately conforms to anatomical shapes. At the nasal tip, the auricular cartilage was covered with a double layer of Permacol™ to form the ideal nasal contour. It is easy to shape and remains without migration or displacement. Afterwards, the author felt two layers of Permacol™ was aesthetically sufficient for the patient with thin nasal skin (case 1, 3), but deficient for the patient with thick facial soft tissues (case 2).

Previous studies demonstrate that Permacol™, when implanted in human body, is readily surrounded by host tissues such as fibroblasts and vascular endothelial cells. Finally, Permacol™ becomes incorporated by tissue ingrowth and
neovascularization[12,13], Hunter et al.[14] observed a Permacol™ explant 15 months post implantation, originally inserted for augmentation rhinoplasty. Macroscopically, Permacol™ was covered with a clear layer of fibrous tissue, characterized histologically by the irregular arrangement of collagen as well as the presence of some cells and elastin fibers. A specimen of Permacol™ ex vivo showed well organized bands of mature acellular collagen. They assumed Permacol™ was integrated or replaced with autogenous tissues. Similar results were reported in the rat model[15]. Furthermore, Hammond et al.[16] suggested that Permacol™ acted as a matrix into which autogenous tissue could grow. From those studies and our own limited experiences with three patients, the author think Permacol™ could be a safe and persistent graft material.

Pitkin et al.[17] inserted forty-five Permacol™ implants for augmentation rhinoplasty over a 4-year period, with only one case of postoperative implant removal. They concluded that Permacol™ seemed to be a biocompatible alternative to conventional grafting materials, with minimal morbidity. Compared to the removal rate of silicone[18] and the infection rate of Gore-Tex[19], Pitkin’s clinical results are encouraging. Moreover, Permacol™ can be safely used in a contaminated field[20]. In our study, immediately after the operation, no patients complained of any foreign body sensations or discomfort at usual daily activities. No acute or chronic inflammatory or immunogenic complications were noted, Fu et al.[21] recommended long-term follow-up for the use of Permacol™ because some graft absorption was noted in their patient, who had undergone nasal profile augmentation. The author followed three patients for more than five years, but there was no sign of graft absorption, Hopkins et al.[22] also report successful long-term use of Permacol™ in rhinoplasty.

In conclusion, we obtained pleasing results in reconstruction of cleft lip nose deformity with simple and safe surgical procedures. In our limited experience with three patients, the author concludes that the Permacol™ can be a reliable surgical option for patients with cleft lip nose deformity. Further studies with larger numbers of patients are required.

References