# SEPTOPLASTY: PATH TO SUCCESS

Proper selection of patient for septoplasty is very important. The indications of septoplasty include a deviated nasal septum producing the symptom of nasal obstruction, which may be unilateral to begin with and then may advance to bilateral. The procedure is often combined with rhinoplasty, FESS, and, anterior cranial procedures. The deformities of nasal septum may include a C or S shaped deviation in horizontal or vertical plane; deviation of its caudal end; bony spurs which occur at junction of bone with the bone or cartilage; and at times there may a crumpled septum in some patients. There may be associated deformities of nasal bridge.

Following are important steps involved in Septoplasty

## THE INCISION:

The site of the incision is very important; in septoplasty give an incision near or only 2-3 mm behind the caudal end of the cartilage, making sure your incision is on the cartilage and not on the soft part of the septum.

Especially when you want to add a strut to support the tip keep the incision near the caudal end, you will find it easier to create a borough for the cartilage piece you want to insert. I always prefer a full length incision from top to bottom so that one gets a full view of the interior of septum.

The mucoperiosteum is loosely attached to cartilage in its superior part so try and look for plain in that area to begin with… when looking for plain use the 15 number blade, go up to cartilage… do not keep on advancing posteriorly in the superficial plain, this makes the flap and liable to tear.

I hope you follow what I am saying. Try to look for plain within millimetres of the site of incision, usually we keep on advancing in superficial plain for a centimetre and make the flap thin which tends to tear…

While you are deepening your incision repeatedly hold and grasp the cut edge of the incision, this helps in bringing the freshly cut layers of plain in grip.

## BREAKING THE BONE-CARTILAGE JUNCTION

Try to break the bone cartilage (BC) junction again in its upper part to begin with because it is lying anteriorly as compared to lower end of the junction which is lying posteriorly. If the Bone-Cartilage junction is too far posteriorly, instead cut the cartilage... ultimately you will reach the bone.

But break the BC junction from top to bottom in one go, because you will find that inferiorly you will encounter spur in some cases and if you do not break the entire junction you will not be able to go on right side of the spur... Once you have broken the junction raise the flap from both sides.

## THE THREE TUNNELS

There are three tunnels, which are made during septoplasty procedure: Left superior (Opposite septal cartilage), Left inferior (Opposite Nasal process of maxilla and palatine bones) and Right inferior on the right side of these processes. Left Superior is created when we raise muco-periosteal flap.

To create left inferior, begin in the bony part posteriorly, just apply some pressure on the bone medially and look you finally see a cleavage...just place your elevator anteriorly and bring it anteriorly. If there is a very acute spur you start raising flap right from the start of the incision i.e. from anterior to posterior.

To create right inferior tunnel, you have to remove septal cartilage strip...if the lower end of cartilage is turned towards right it can be ticklish then try to remove it just as in SMR.

Once you have created these tunnels then removing bony spur becomes very easy...remember the septal processes of maxilla are usually very thin bones.

Detaching cartilage from its posterior and inferior attachments will de-spring it, but if there is a thickening of cartilage or a structural bend of cartilage you either do SMR type removal or make it soft by giving crisscross incisions. Once you have mastered basic septoplasty then you can play with the cartilage and try to give it the desired shape.

If you have torn flap on both sides give up the idea of removing bone or cartilage or replace it because it is better to have a deviation than to have a perforation.

## FINALLY CORRECTING CAUDAL END

First give an incision near caudal end, meticulously raise flap on both sides, cut the redundant piece of caudal end millimetre by millimetre. You can stich it to opposite side of deviation to keep in midline. The cartilage is very soft and easily traumatised, so hold it with a non-traumatic septum holding foreceps.

You can now create a borough for placing a strut if it is required. Transfixion suturing to straighten the cartilage is also useful step. Always begin by placing the pack first on the side of deviation.