The nose is the leading feature of the face, and it is often its characterizing or defining element. A large, unbalanced, or crooked nose draws attention and detracts from what otherwise may be an attractive face.

On the other hand, a nose in balance with the other facial features can be easily overlooked. Impressions will be based on revealing features such as luminous eyes or captivating lips. My practice’s goal for nasal reshaping is to create an attractive nose that is in harmony with the rest of the facial features, diverting attention away from the nose and directing it elsewhere.

In the past 10 years, there has been a large shift in the way the nose is appreciated, by both the rhinoplasty physician and the patient. Much of this stems from the evolving definition of what makes a nose appear attractive. In today’s multi-ethnic, one-world society, a nose that is a blend of all cultures is more appealing.

No longer does a small, pinched, turned-up nose grace the covers of the fashion magazines, nor is it displayed by pop divas. Like our cross-cultural fashion icons, our patients are now requesting a more full-bodied nose with a strong profile and a defining tip. I am now even receiving not-so-infrequent requests to place a small dorsal convexity or bump onto what would be a seemingly beautiful straight profile.

Patients furnish pictures of famous Eurasian models with long, strong, elegant ethnic noses and a tiny bump on the bridge, and ask for the same. The changing aesthetic, along with lessons learned from the past, is resulting in new surgical approaches and philosophies by rhinoplasty physicians.

In addition, my nasal-reshaping patients, like all of today’s aesthetic patients, are looking for quality results, but they also want them to be achieved quickly. The rhinoplasty surgeon is no longer immune from the “no-downtime—minimally invasive” tidal wave enveloping aesthetic medicine. Rhinoplasty surgeons have responded to the demands. From fillers and botulinum toxin Type A (BTNA) to new surgical grafting techniques, there are a few new ideas for altering nasal appearance.

Rhinoplasty remains one of the most difficult procedures to do well in plastic surgery. There are multiple dependent anatomic components, factors, and nuances to negotiate and manage during surgery. Seemingly minor adjustments made at the time of surgery can result in dramatic changes years later—hence, the apparent increase in rhinoplasty revisions.

The revision rate for rhinoplasties performed by experts has been reported to be as low at 4%; however, on the whole, it is likely underreported. Few physicians report the rate of their own revisions, and many poor outcomes do not reveal themselves until decades after the procedure.

Unfortunately, too often these aesthetically bad outcomes are also associated with nasal breathing problems. These patients often seek attention for breathing problems as much as for appearance issues.

Grafting techniques used in revision procedures have led to new ways of thinking in primary rhinoplasty. In the attempt to reduce bad outcomes and nasal cripples, newer surgical techniques have been devised to build a stronger nose that is still aesthetically appealing.

A better nose is achieved through more structurally stabilizing grafting and fixation of the nasal cartilage components. Aesthetic impact factors are long appreciated by our artistic colleagues, such as light reflections and shadows, but are now better appreciated and more heavily emphasized by surgeons. The tools for creating such an outcome are largely based on what we have learned from the external rhinoplasty approach.

External or Internal Rhinoplasty?

Rhinoplasty that used to be commonly performed using an internal (or endonasal, or closed) approach—meaning no external incision—was the standard for a generation. These rhinoplasties were mostly reductive in nature, and were
accompanied by sweeping excisions of cartilage and bone. However, too many rhinoplasty patients ended up with distorted cartilages, asymmetric sidewalls, loss of tip projection, and difficulty breathing years later.

Learning from earlier experiences, rhinoplasty surgeons of the 1990s popularized the open approach—entering through an external columellar incision—with significant cartilage grafting. This resulted in a stronger, more solid nose that was better built and able to withstand aging changes. However, postoperative recovery can be longer with this method, and noses appear larger for longer time periods. Many months may be required before an attractive nose becomes evident.

This is out of character for most of today’s aesthetic-seeking patients. Thus, a middle ground evolved, in which grafting techniques used in the open approach can be translated to the closed approach, resulting in a well-supported structural nose that does not take as long to heal and does not look as big for as long.

Following surgery, patients appreciate the quicker recovery, along with rare and minimal periorbital edema and bruising. But in most hands, a healing period is still required before the nose reveals itself. This can take anywhere from a few weeks to months.

So, despite the appeal for a permanent change to the nose, many of my patients are still requesting a quicker fix. They have become comfortable with and accustomed to the high satisfaction and reliability of the injectables, and they want to know if injectables are an honest alternative for making their noses more appealing.

Fillers and Botulinum Toxin Type A

Noninvasive methods for the nose, including fillers and BTXA, have a limited but established role in improving nasal appearance. BTXA and fillers can be used to subtly but quickly change the appearance of the nose, allowing a person the option of improving his or her appearance for an upcoming event.

For the patient with a dependent or ptotic tip and a snarled upper lip, BTXA can provide no-downtime help. BTXA can rotate the tip of the nose 10° upward, resulting in a gentle curve of the tip and nostrils. A subtle relaxation of the upper lip is also appreciated.

Three to five units of BTXA placed in each of the depressor septi nasi muscles (which originate on the media crura and interdigitate with the orbicularis oris muscle) and each of the levator labii superioris alaeque nasi muscles (which originate on the frontal process of the maxilla and insert in the skin of the ala and upper lip) will provide for this subtle but effective adjustment to the nose.

BTXA can also be placed in the nasal “bunny lines” that stem from overactive nasalis muscles situated on the proximal lateral nasal sidewall. Although not a frequently requested area of BTXA treatment, relaxing these muscles will result in a reduction in the distracting wrinkles accentuated by squinting, smiling, and laughing.

Fillers also have a role in nasal reshaping, especially in the postrhinoplasty defect. For the patient interested in altering the appearance of his or her nose and improving breathing at the same time, there is no substitute for a well-done surgical procedure. But there is the occasional patient who absolutely refuses to undergo surgery or cannot medically tolerate a surgical procedure, or even perhaps a postrhinoplasty patient who is mostly satisfied with the result but is bothered by a mild defect that does not seem worthy of a surgical revision.

In such situations, filler may be an option. The hyaluronics, along with calcium hydroxyapatite (CAH) and silicone, have been used to fill in minor defects of the nose and provide for a streamlined dorsum or tip that was once small dent away from looking pristine. The hyaluronics, placed deeply along depressed cartilage defects, can camouflage what would otherwise be a shadow-emitting depression.

CAH placed deep along the bony dorsum can make a curved nose look straight...
Nonsurgical Rhinoplasty Case 2

A 42-year-old female who had undergone functional rhinoplasty 1 year prior to presentation complained of a scooped-out appearance in her nose. She had no breathing difficulties but wanted an improvement in nasal appearance. The risks and benefits of a revision rhinoplasty with ear- or rib-cartilage grafting were discussed with the patient.

Although she recognized the value and permanent nature of undergoing a revision rhinoplasty, she was absolutely opposed to another surgical procedure and wanted a quicker solution that entailed no downtime. She indicated that she was quite sure another surgical procedure was not for her.

On examination, the frontal view revealed a washed-out middle vault with a well-defined appropriate nasal tip. The lateral view showed a saddle-nose deformity. A calcium hydroxyapatite (CAH) filler was recommended to temporarily improve the appearance of her nose. The risks and benefits were discussed, and she decided to undergo the procedure.

Topical anesthetic containing benzocaine–lidocaine–tetra-caine was allowed to sit on the nose for 20 minutes, after which 0.7 mL of CAH was placed deep along her bony and cartilage nasal structures and massaged into place. She had mild bruising and swelling, but this was easily camouflaged the next day.

One month later, she returned and was happy with her outcome (Figure 2). Two years later, she continues to return for follow-up injections when the CAH begins to dissipate.

References