

THE VALUE OF THE MAXILLARY-PREMAXILLARY APPROACH TO SEPTAL SURGERY

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Modern nasal septal surgery is based on sound physiologic knowledge as well as a detailed knowledge of anatomy. Rhinologic surgeons have long searched for a satisfactory way of handling all elements of the nasal septum and its related components of the external and internal nose. The modern rhinologic surgeon cannot be satisfied with techniques that remove only cartilage and bone, often behind the important obstruction, leaving an obstructed valve or dislocated caudal portion of the septum. Most certainly his patient is entitled to a better chance for relief of his symptoms than that which a "routine submucous resection" can offer.

Furthermore, the modern rhinologic surgeon needs a procedure that is reconstructive and can be combined with procedures of a rhinoplastic nature, so that the whole nose can be reconstructed in proper relationships that will produce a functional reconstruction as well as an anatomic reconstruction. Rhinoplastic procedures that ignore the role of septal pathology that exists are doomed to functional failure.

For many years septal surgery was done according to the methods described by Ingalls, Freer, Metzenbaum, and others. The anatomy of the septum had been described by Zuckerkandl and by Mosher. The importance of some of the anatomy was ignored.

The classic submucous resection was unable to correct caudal septal deformities including those of the premaxilla and maxillary spine. Obstructions at the valve area were usually uncorrected, and deviations of the cartilaginous vault of the nose correctable by adequate septal surgery remained. Sagging of the upper lateral cartilages and retraction of the columella were frequent sequelae of submucous resection. Often perforations resulted from failure to properly elevate perichondrium and periosteum, as well as from coapting tears in the flaps. Some of these, especially from the former cause, became manifest weeks, months, or even several years after operation.

After years of developing the technique, Cottle, Loring, Fischer, and Gaynon finally reported, in 1957, the maxilla-premaxilla approach to extensive surgery of the nasal septum. This approach gives the surgeon complete exposure of all parts of the nasal septum. It allows him to combine reconstructive septal surgery with surgery of the external nasal pyramid with preservation of the mucosal attachments and relationships to all nasal components. It allows work to be done on any part of the septum and the choanae. The base can be narrowed or prevented from being broadened by undermining and proper insertion of base sutures through the hemitransfixion incision. The maxilla-

premaxilla approach is ideal for septal work on children at any age. Because this approach permits exposure of all parts of the nasal septum, pathologic changes often unrecognized on preoperative examination can be located and corrected. Scar tissue, particularly around the premaxillary and spinal area, is readily handled. Septal perforations may be repaired, especially those that occur at the time of surgery.

The premaxilla can be mobilized or removed to unlock the septal mosaic. The caudal end of the septal cartilage can be reconstructed and any part or all of the septum can be removed and reconstructed.

The nasal dorsum may be approached and suitable material implanted into the dorsum through the hemitransfixion incision.

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