DRS. ERIŞIR AND TAHAMILER RESPOND:

Most articles that compare osteotomy methods indicate a preference for a particular technique. In our article (Aesthet Surg J 2008;28:518–520), it was clear that we prefer 2-mm V-shaped osteotomes to 4-mm osteotomes. However, some important issues raised in this study require further clarification.

Readers will note that in the last stage of our procedure we performed right lateral osteotomies with a 2-
mm V-shaped osteotome and that left lateral osteotomies were performed with a 4-mm straight Cottle osteotome. The factor of right lateral versus left lateral as it relates to the surgeon’s dominant hand is not significant to the study results. Our experience with more than 5000 rhinoplasties indicates that, in treatment of a symmetric nose, there is no significant difference in results between the left and right side with respect to the incidence of edema or ecchymosis, regardless of the dominant hand of the surgeon. As shown in Figure 1, when both sides

\[ \text{Figure 1. Immediate postoperative results of osteotomy in a 24-year-old woman. Both sides of the nose were treated with a 2-mm osteotome.} \]

\[ \text{Figure 2. Immediate postoperative results of a standard osteotomy in a 22-year-old woman using saws and chisels show the severity of edema and bilateral eye closure.} \]

\[ \text{Figure 3. A, Normal nasal bone thickness is not more than 1.5 mm. B, Transillumination of osseous structure with 1–1.5 mm thickness.} \]
of the nose are treated using a 2-mm V-shaped osteotome, there is little difference in the degree of edema and ecchymosis.

Edema and ecchymosis are two parameters that have been used to compare different methods of osteotomy. Most surgeons are familiar with the severity of edema and ecchymosis resulting from standard osteotomies using saws and 4- to 6-mm chisels. Both eyes may be closed nearly completely, so that patients are unable to see anything for at least 24 hours postoperatively. No one can be happy with such results. Figure 2 illustrates the degree of eye closure 24 hours after performance of a standard osteotomy.

All investigations confirm that normal nasal bone thickness is between 1 and 1.5 mm at the osteotomy sides. The nasal bone thickens as it descends laterally, to the extent that osteotomy can no longer be performed. In some traumatic cases, the bone can be wider than 3 mm. Such cases were excluded from our study. Figure 3 illustrates the normal nasal bone structure.

Lateral osteotomy is one of the most important steps in rhinoplasty. Proven and reasonable techniques will be accepted by most surgeons. Currently, most surgeons recognize the usefulness of 2- to 3-mm osteotomes.

In summary, surgeons should not conclude that all procedures performed with 2-mm osteotomes will achieve results free of edema and ecchymosis. The experience of the surgeon plays a major role in the degree of postoperative swelling.

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