The primary objective of rhinoplasty surgery is to create an attractive, functional nose without any surgical stig mata. However, this goal can only be achieved if the surgeon understands the direct linkage between surface aesthetics, underlying anatomical structures, and functional factors. The appearance of an attractive nose is created by certain lines, shadows, and highlights covering the nasal dorsum, tip, and base. During rhinoplasty surgery, these surface aesthetics, with their proportions and breakpoints, must be maintained, emphasized, and created where they are absent. The following aesthetic concepts and surgical techniques have been used in 257 consecutive rhinoplasties performed in the past 3 years. Patients in this series were 80% female and 20% male, with an age range of 19 to 56 years (average, 27 years) and an average follow-up period of 1.5 years. Two cases of bleeding (0.78%) were observed, with no cases of infection. The overall rate of revision was 5% for the whole series.

Aesthetic Nasal Polygons

The nose can be analyzed as aesthetic units using the concept of geometric polygons. A polygon is defined as a plane figure with at least 3 straight sides and angles. Evaluation of the nasal surface using polygons allows identification of shadows and highlights, which are linked to the underlying anatomic structures that can be modified surgically. Thus, the goal of surgery is to modify, rearrange, and/or reconstruct the nasal infrastructure, thereby creating nasal surface polygons that are symmetrical and aesthetically pleasing.

Working from the glabella downward, we can define the glabella polygon, the dorsal bone polygon, the dorsal...
cartilage triangle, the lateral bone polygons, the upper lateral polygons, the dome triangles, the lateral crus polygons, the interdomal triangle, the facet polygons, the infralobular polygon, the columellar polygon, and the footplate polygons (Figure 1). The intersection and juxtaposition of the polygons define the “lines” and “points” that rhinoplasty surgeons use to analyze the nose. Although somewhat tedious to define, these polygons are easily sketched on standard nasal photographs and quickly mastered for operative planning, as shown in the accompanying video (Video 1), which is available at www.aestheticsurgeryjournal.com. You may also use any smartphone to scan the code on the first page of this article to be taken directly to the video on www.YouTube.com.

**Dorsal Aesthetic Lines**

Classically, the nose is shown on frontal view with 2 divergent concave lines that extend from the supraorbital rim through the radix area and then continue as paired lines to the nasal tip. However, these traditional dorsal aesthetic lines are slightly different when viewed through the nasal polygon aesthetic unit concept. As seen in Figure 1, the dorsal aesthetic lines should have a fusiform pattern starting at the brows, with the nasal radix area being narrow, the keystone area wider, and the supratip region narrow again before ultimately diverging at the tip. This fusiform pattern is important in creating a natural-looking aesthetic dorsum. One can clearly see the natural widening of the keystone area on oblique view (Figure 2). We define the dorsal aesthetic lines as corresponding to the lateral edges of the glabella polygon, extending caudally in between the lateral bone polygons and the dorsal bone polygon, between the upper lateral polygons and the dome triangles, and between the lateral crus polygons and the dome triangles (Figure 1).

**Lateral Aesthetic Lines**

These lines are created by combining the lateral edges of the lateral bone polygons, the upper lateral polygons, and partially by the lateral crus polygons (Figure 1). The importance of the lateral aesthetic lines is to emphasize the triangularity of the nose and to offset the nose from the cheek. The lateral aesthetic lines are as important as the dorsal subunit but not as complex. The nasal base on both sides should also produce a highlight, creating 2 convergent and convex lines extending from the supratarsal folds toward the nasal alae, with the narrowest point being at the nasal radix area.

**The Scroll Line and the Lateral Crus Resting Angle**

The scroll line is a groove indicating the transition from the upper lateral polygon to the lateral crus polygon (Figure 1). The scroll junction between the upper lateral cartilage (ULC) and the lateral crus marks the transition from the static nasal body to the dynamic moving nasal tip. The groove over the scroll area should meet in the center to create a supratip breakpoint, especially in the female profile. The supratip breakpoint corresponds to the common apices of the dome triangles and the interdomal triangle.

The lateral crura have a position in space that can be defined in 2 different planes. The first is the lateral crus longitudinal axis, which represents a divergence of the lateral crus relative to the contralateral lateral crus (ie, the intercrural angle). This divergence can be described as a lateral crus longitudinal axis, which intersects the lateral canthus of the ipsilateral eye in its correct position. The second is the axial rotational position of the lateral crus, giving rise to the concept of the lateral crus resting angle, which we believe should have a roughly 100° inclination with the upper lateral cartilage (Figure 3). The lateral crus, with a normal resting angle, essentially lies horizontal with the cephalic margin slightly superior to the caudal margin. When the cephalic edge is more superior when compared with the caudal edge, both structure and aesthetics may be negatively affected.
Establishing a correct resting angle of the lateral crura is vital to the surface aesthetics of the tip. A resting angle of 100° or less creates a well-defined scroll groove. Lateral crura with an abnormal resting angle will cause a loss of the scroll groove and excessive fullness in the supratip region, making the nose look as though the lower lateral cartilages (LLC) were cephalically malpositioned. We describe this abnormality as a pseudocephalic malposition of the lateral crura, as seen in Figure 3A. A resting angle of 180° or more results in medialization of the lateral crus cephalic border compared with the ULC, hence creating a “pinch nose” appearance.

**The Nasal Tip**

Sheen and Sheen described the ideal tip shape as 2 equilateral geodesic triangles with a common base formed by a line connecting the 2 domes. They noted that the highest projecting point of the tip should lie along the apogee of the curved line that connects both domes. They defined the intercrural distance as the distance between the domes, which also represents the common base of the 2 geodesic triangles. Daniel noted an angle of dome definition at the domal junction line, with the most aesthetically pleasing tips having a convex domal segment and concave lateral crus. In contrast, our concept of tip surface aesthetics is composed of 2 dome triangles, an interdomal triangle, a pair of facet polygons, and an infralobular polygon (Figure 1).

**The Nasal Tip Diamond**

The nasal tip should show “double light reflections” when photographed with a standard 2-flash technique on frontal view (Figure 2A). These reflections create a “diamond”-shaped highlight through combination of the dome triangles,
the interdomal triangle, and the infralobular polygon. Proper creation of this “diamond shape” light reflection is characteristic of an aesthetic result following tip surgery.

**Tip-Defining Points**

The oblique and lateral views of the nose reveal important breakpoints at the tip, which have been defined previously in the literature under various nomenclature. Our approach to the tip surface structural anatomy requires definition of specific points—namely, the superior tip (Ts), inferior tip (Ti), medial rim (Rm), and lateral rim (Rl) points for precise description of the tip polygons (Figure 4).

The Ts point corresponds to the combined vertices of the dome triangles, which will be described later. The Ti points correspond to the inferomedial corners of the dome triangles—hence, the 2 inferolateral vertices of the interdomal triangle. These points should ideally be positioned in the same vertical plane in the lateral profile view, to create an aesthetically pleasing tip shape. The Rm points represent the medial ends of the lateral crura caudal border, while the Rl points correspond to the lateral ends of the lateral crura at the caudal border (Figure 4). These landmarks and breakpoints help define and evaluate the tip polygons, thus facilitating analysis of the nasal surface aesthetics.

**Dome Triangles and the Interdomal Triangle**

The dome triangles are a pair of isosceles triangles, in between the Ts, Ti, and Rm points, each having their bases in contact with the facet polygons. The interdomal triangle, on the other hand, is the triangle in between the dome triangles created by Ts and bilateral Ti points (Figures 1 and 4). The base of a dome triangle should ideally be half the length of the 2 sides. The base of the triangle should never be narrowed. Any attempt to narrow the caudal base will result in widening of the infralobular polygon, which results in medialization of the caudal edges of the lateral crura and an unwanted notching effect on the nostrils. The base of the interdomal triangle is the widest area of the tip, created by a line connecting the 2 Ti points (Figures 1 and 4). The medial edge of each dome triangle corresponds to the lateral edge of the interdomal triangle.

One can devise a relative ratio comparing tip width with nasal width at the keystone area. In females, the tip-to-keystone width ratio is wider, which accentuates femininity, while the ratio is narrower in males (Figure 5). The superior angle of the interdomal triangle, corresponding to the angle formed by the 2 dome triangles, is also an important structural detail, with an ideal value of 80° to 90° in males and a slightly wider 90° to 100° in females (Figure 5).

**The Facet Polygon**

The facet polygon is a critical surface structure in the nasal tip that should be respected in tip plasty. Defined as the polygon in between the Ts, Rm, and Rl and C’ points (Figure 4), the distance between the dome triangles and the rim should be at least equal to the length of the base of the dome triangles, creating a well-defined facet polygon in between (Figure 1). Caudal trimming of the lateral
crura instead of cephalic trimming may be necessary for creating a well-defined facet polygon.

The Infralobular Polygon

The infralobular polygon is formed between the interdomal triangle and the columellar polygon. The superior edge of this polygon corresponds to the interconnection of the T′, points. The base of the infralobular polygon is at the columellar breakpoint, represented by the interconnecting line between the C′ points (Figure 4), which is ideally placed at the apical edge of the nostrils. A lower columellar breakpoint will result in a more exposed nostril on frontal view. The infralobular polygon has a relatively wider superior edge in females than in males.

Columellar and the Footplate Polygons

The columellar polygon is located between the infralobular polygon and the footplate polygon. It begins at the columellar breakpoint and continues down until the divergence of the medial crura. The footplate polygon begins at the divergence of the medial crura footplates and ends just above the lip junction. These 2 polygons reflect the underlying division of the medial crura into a columellar segment and a footplate segment.²,⁵

Surgical Techniques

Analysis of surface aesthetics allows the surgeon to define the deformities, establish goals, and then determine how to modify the underlying structures. Two examples of utilizing the polygon concepts in rhinoplasty surgery occur in tip surgery and dorsal reduction.

Tip Suture Technique

Tip modification is one of the most complex steps in rhinoplasty due to the tip’s 3-dimensional (3D) structure and the interrelationships of the alar cartilages. Many suture techniques have been developed to narrow and define the nasal tip, in addition to various grafts that have also been designed and proposed for tip modification.⁶ The nasal tip is formed in part by the middle crura in a vertical plane and the lateral crura in a horizontal plane, with their junction being a 2-dimensional axis that includes a rotational position. The lateral crus has a 3D spatial position with relation to the nasal anatomy and the contralateral crus. A 3D reconstruction of the whole structure is essential to achieving the desired surface aesthetics.¹,³

The cephalic dome suture is a lateral crus-angling suture that, when placed properly, can adjust the lateral crus in the correct spatial position with the desired resting angle (Figure 6). This suture stabilizes the middle and the lateral crura in different planes, thereby correcting the resting angle of the lateral crura, evertting it onto the correct surface polygon. The suture can be placed using either an open or closed approach, the latter through the dome delivery technique. A video of this technique (Video 2) is available at www.aestheticsurgeryjournal.com. You may also use any smartphone to scan the code on the first page of this article to be taken directly to the video on www.YouTube.com.

The lateral crura, domes, and middle crura are dissected in the subperichondrial plane. This maneuver results in a more pliable lateral crus cartilage that is easier to shape with sutures. The lateral crura are separated from each other and cephalic resection is performed to reduce the lateral crural width if necessary. The amount of cephalic resection required when using the cephalic dome suture is usually less than the resection required when classical transdomal sutures are used. In fact, resection should be just enough to enable rotation of the lateral crus, hence correcting its resting angle. A wide lateral crus can limit this movement, preventing the cephalic dome suture to correct the resting angle. On the other hand, too much resection results in an empty space between the lateral crus and the ULC, which is not favorable. Caudal resection of the lateral crura is performed to adjust and manipulate the facet polygon. The location of the new tip-defining point is determined and marked. The cephalic dome suture is then inserted at this point to increase tip definition and projection, as well as stabilization of the lateral crus resting angle. The cephalic dome suture is applied through the cephalic edges of the medial and the lateral crura, 2 to 3 mm posterior to the dome, using a 6-0 PDS suture on a 10-mm round needle. Extra care is taken to keep the suture knot posterior. If the deformity is severe or the cartilages are too rigid to reshape easily, extra sutures can be added. If a sharp dog-ear deformity is produced at the cephalic edge of the new dome, it can be resected as a small wedge excision. The cephalic dome suture is the only single-tip suture to create and manipulate this ideal anatomy. This procedure also produces a
A 4- to 5-mm area of contact between the medial and lateral crura of both sides that stabilizes the tip complex in a very firm way. Functionally, this stability of the lateral crura significantly reduces the need for columellar struts, alar rim grafts, and lateral crural strut grafts. On lateral view, the cephalic dome suture elevates the \( T_s \) point and positions it 1 to 2 mm anteriorly. In contrast, a partial dome division and dog-ear resection lowers the \( T_s \) point. This maneuver can help to maintain the same-plane position of both the \( T_s \) and \( T_i \) points on the lateral profile view.

In conclusion, correcting the resting angle of the lateral crus using a cephalic dome suture has the following effects: it (1) moves the lateral crus caudal border anterolaterally, (2) moves the cephalic border posteromedially, (3) preserves or enhances the facet polygon, and (4) improves formation of the dome triangles, the infralobule polygon, and the interdomal triangle surface polygons by preserving the dome divergence angle.

**Dorsal Modification—The Libra Graft**

Reducing the nasal dorsum is a common surgical maneuver performed in primary rhinoplasty. It is often achieved by rasping the bony vault and excising the cartilaginous vault. Currently, reconstitution of the dorsum can involve narrowing the defect with osteotomies, insertion of spreader grafts, or turning over the upper lateral crura as spreader flaps.\(^{10-17}\) The natural fusiform dorsal lines of the nasal dorsum are created anatomically by the spread of the cartilaginous vault and its overlying cap of bony dorsum, with the widest point at the keystone area (Figure 2). In addition, the dorsal septum is 1 to 2 mm below the ULC in the keystone area. This difference in height results in a longitudinal groove, which is filled with fibrous tissue. Previously, the excised dorsal cartilaginous hump has been used as spreader or dorsal grafts.\(^{18,19}\) Our approach to dorsal reconstruction is to recreate the fusiform anatomy using rotated halves of the excised hump to produce a natural, aesthetic dorsal appearance.

A transverse section of the keystone area resembles the shape of the Libra scales; hence, we coined the term *Libra spreader graft* (Figure 7). The operation can be performed through an open or closed approach via a subperichondrial/subperiosteal dissection. A video of this technique (Video 3) is available at www.aestheticsurgeryjournal.com. You may also use any smartphone to scan the code on the first page of this article to be taken directly to the video on www.YouTube.com. The ULC and septum are dissected in the subperichondrial plane with a blunt elevator to keep the septum’s transverse segments intact. The cartilaginous hump is removed en bloc with angled scissors, followed by careful elevation of the bony septum using a straight 4-mm osteotome. It should be noted that dorsal resections exceeding 5 mm require concurrent excision and repair of the underlying mucosa to prevent dorsal opening.

The excised cartilaginous vault is then split longitudinally with a #15 blade and the 2 pieces rotated 90° to create Libra spreader grafts. Rotating the split halves produces a smooth, straight dorsum and facilitates trimming the final graft shape before insertion. The grafts are placed between the septum and the ULC, which are then stabilized caudally with 2 horizontal sutures to the septum (Figure 7). Creation of the graft from the dorsal hump makes graft harvesting unnecessary from any other site, which is another major benefit of this technique. Use of the Libra spreader grafts results in a groove in the center of the middle vault, as in natural anatomy, making it possible to create the adequately sharp dorsal aesthetic lines (Figure 7). Anatomically, the Libra spreader grafts’ anterolateral wings increase the dorsal height by 1 to 2 mm.
while also widening the dorsal width at the keystone area yet tapering rapidly toward the tip. The reconstruction achieved with this technique recreates a more natural anatomy and results in natural fusiform dorsal aesthetic lines.

**CLINICAL CASES**

Two clinical cases demonstrate utilization of the surface polygon concept for assessment of the clinical deformities and selection of the appropriate surgical techniques.

**Case 1**

The patient was a 30-year-old woman who underwent a preoperative frontal nasal analysis that revealed a symmetric nose with thin skin. The lateral crura were wide and convex. The lateral crura resting angle was about 145° bilaterally, as measured in the preoperative photograph. The lateral view analysis exhibited a tension nose with an increased tip projection, a short and blunt infralobule polygon, and a high, wide footplate polygon. The dorsal bone and cartilage polygons were displaced anteriorly (Figure 8).

The operation was performed through the closed approach via the dome delivery technique. High transfixion and intercartilaginous incisions were made and dissection performed in the subperichondrial plane. Mucosal tunnels were created and the dorsal component resected by 3 mm. The septum was not dissected. Rim incisions were made and the LLC were dissected in the subperichondrial plane. The lateral crura were resected cephalically by 3 mm, leaving a 6-mm crural strip. The lateral crural steal procedure was applied with 3-mm advancement of the lateral crura to the middle crura for both domes. Cephalic dome sutures were used to internally rotate the lateral crura, setting the intraoperative resting angle to 100° and establishing the dome and interdomal triangles as well as the infralobule and columellar polygons. The dog-ears created at the cephalic edges of the triangles were resected, shifting the Tc point to a more posteroinferior position. Care was taken to place the Th, Tc, and Rm points in the same vertical plane. The dome triangles were sutured together at their apices with a figure-of-8 suture, setting the interdomal triangle superior angle at 100°.

A columellar strut graft was prepared and placed in its pocket. The medial crura were then sutured to the caudal septum 5 mm below the domes to create the columella or C′ breakpoint. The footplates were set back 4 mm each and sutured to each other, narrowing the footplate polygons. The lateral crural steal also increased the infralobule and facet polygon heights, enhancing the facet polygon silhouette. Lateral internal osteotomies were made in a high-low-high manner using a V-pointed, straight 3-mm osteotome combined with external osteotomies using a 1-mm osteotome. The Libra spreader grafts were then used for dorsal reconstruction. Pitanguy’s midline ligament and the bilateral scroll ligaments were preserved and plicated at the end of the procedure. A total reduction in nasal projection caused widening of the nostrils, and a 3-mm nostril resection was done.

The 1-year postoperative photographs reveal clearly defined surface polygons (Figure 8). The fusiform dorsum was created using the Libra grafts, with a small 2-mm hump seen on the 45° oblique view where the dorsal cartilage and bone polygons join. The lateral crus polygons were shortened through cephalic trimming of the cartilage, setting the scroll groove closer to the tip. This can be seen clearly in the 45° oblique view. The dome triangles can be visualized clearly on the frontal view, whereas the lateral crural shading can be clearly defined via the Rm and Rl points on the lateral view. This distance also defines the well-enhanced facet polygons. A natural triangular nasal shape can be clearly seen on the basal view, without any use of rim grafts or lateral crural strut grafts, thanks to the

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**Figure 7.** Composite cartilaginous and bony hump removal (A) is followed by longitudinal splitting of the graft (B) and 90° rotation of the 2 pieces (C) to create the Libra spreader grafts. The grafts are then placed between the septum and the upper lateral cartilage (D) and stabilized with 2 horizontal sutures to the septum.
Figure 8. (A, C, E, G) This 30-year-old woman presented with tension nose, wide and convex lateral crura, a resting angle of about 145° bilaterally, increased tip projection, a short and blunt infralobule polygon, high and wide footplate polygons, and anteriorly displaced dorsal bone and cartilage polygons. (B, D, F, H) One year after rhinoplasty through the closed approach via the dome delivery technique, with the resting angle set to 100° bilaterally, establishing the tip polygons and creating a fusiform dorsum.
Figure 8. (continued) (A, C, E, G) This 30-year-old woman presented with tension nose, wide and convex lateral crura, a resting angle of about 145° bilaterally, increased tip projection, a short and blunt infralobule polygon, high and wide footplate polygons, and anteriorly displaced dorsal bone and cartilage polygons. (B, D, F, H) One year after rhinoplasty through the closed approach via the dome delivery technique, with the resting angle set to 100° bilaterally, establishing the tip polygons and creating a fusiform dorsum.
Figure 9. (A, C, E, G) This 25-year-old woman presented with a left axis deviation, bulbous tip, indistinct domes, short and convex right lateral crus, resting angle of about 150° bilaterally, inadequate tip projection and rotation, short infralobule polygon, high footplate polygons, and anteriorly displaced dorsal bone and cartilage polygons. (B, D, F, H) One year after rhinoplasty through the closed approach via the dome delivery technique, which corrected the axis deviation and set the resting angle to 100° bilaterally, establishing the tip polygons and creating a fusiform dorsum.
Figure 9. (continued) (A, C, E, G) This 25-year-old woman presented with a left axis deviation, bulbous tip, indistinct domes, short and convex right lateral crus, resting angle of about 150° bilaterally, inadequate tip projection and rotation, short infralobule polygon, high footplate polygons, and anteriorly displaced dorsal bone and cartilage polygons. (B, D, F, H) One year after rhinoplasty through the closed approach via the dome delivery technique, which corrected the axis deviation and set the resting angle to 100° bilaterally, establishing the tip polygons and creating a fusiform dorsum.
correct lateral crural resting angle that strengthens the rims. A high starting osteotomy prevented narrowing of the lateral aesthetic lines at the middle vault level, creating a natural nasal shape. Plication of Pitanguy’s midline ligament and the scroll ligaments resulted in a maintained supratip breakpoint despite a total reduction in tip projection in the 1-year postoperative period.

Case 2

The patient was a 25-year-old woman who underwent a preoperative frontal nasal analysis revealing a left axis deviation, bulbous tip, and indistinct domes. The right medial crus was situated lower than the contralateral side, and the right lateral crus was short and convex. The lateral crura resting angle was about 150° bilaterally as measured in the preoperative photograph. The lateral view analysis exhibited inadequate tip projection and rotation with an acute nasolabial angle. The dorsal bone and cartilage polygons were displaced anteriorly. The facet polygons were indistinct and the infralobule polygon was short. The footplate polygon heights were also increased (Figure 9).

The operation was performed through the closed approach via the dome delivery technique. High transfixion and intercartilaginous incisions were made and dissection performed in the subperichondrial plane. Mucosal tunnels were created and the dorsal component resected by 3 mm. The septal base was reduced by 2 mm, and scoring was applied to attain middle line axis. Rim incisions were made and the LLC were dissected in the subperichondrial plane. The lateral crura were resected cephalically by 3 mm, leaving a 6-mm crural strip. The lateral crural steal procedure was applied to the right side, with 3-mm advancement of the lateral crus to the middle crus and 4-mm advancement on the left side. Cephalic dome sutures were used to internally rotate the lateral crura, setting the intraoperative resting angle to 100° and establishing the dome and interdomal triangles as well as the infralobule and columellar polygons. The dog-ears created at the cephalic edges of the triangles were resected, shifting the \( T_s \) point to a more posteroinferior position. Care was taken to place the \( T_s \), \( T_r \), and \( R_m \) points in the same vertical plane. The dome triangles were sutured together at their apices with a figure-of-8 suture, setting the interdomal triangle superior angle at 100°.

A columellar strut graft was prepared and placed in its pocket. The medial crura were then sutured to the caudal septum 5 mm below the domes to create the columella or C’ breakpoint. The footplates were set back 2 mm each and sutured to each other, narrowing the footplate polygons. The lateral crural steal also increased the infralobule and facet polygon heights, enhancing the facet polygon silhouette. Lateral internal osteotomies were made in a high-low-high manner using a V-pointed straight 3-mm osteotome combined with external osteotomies using a 1-mm osteotome. The Libra spreader grafts were then placed for dorsal reconstruction. Pitanguy’s midline ligament and the bilateral scroll ligaments were preserved and plicated at the end of the procedure.

The 1-year postoperative photographs reveal clearly defined surface polygons (dome, interdomal, infralobule, columellar) as well as a corrected lateral crural resting angle (Figure 9). Correction of the resting angle between the ULC and the lateral crura also enhanced the scroll groove. This can be seen clearly in the 45° oblique view. The facet polygons were enhanced and the fusiform dorsum was created using the Libra grafts, with a small 2-mm hump seen on the 45° oblique view. The dome triangles can be visualized clearly on the frontal view (not seen in the preoperative photographs), whereas the lateral crura shading can be clearly defined via the \( R_m \) and \( R_l \) points on lateral view. This distance also defines the well-enhanced facet polygons. A natural triangular nasal shape can be clearly seen on basal view, without any use of rim grafts or lateral crural strut grafts. A high starting osteotomy prevented narrowing of the lateral aesthetic lines at the middle vault level, creating a natural nasal shape. Plication of Pitanguy’s midline ligament and the scroll ligaments resulted in a maintained supratip breakpoint that was enhanced in the 1-year postoperative period.

CONCLUSIONS

Nasal aesthetics can be defined in terms of polygons and triangles, with new emphasis on the lateral crus spatial position and the proper lateral crus resting angle. For example, the critical “tip diamond” is created by the interrelationship between the dome triangles, the interdomal triangle, the facet polygons, and the infralobule polygon. This type of analysis has led to new surgical techniques. The cephalic dome suture is used to create the desired tip by emphasizing the dome triangles, the infralobule polygon, and the interdomal triangle aesthetic subunits. The Libra graft is used to create a natural fusiform dorsum with reconstruction of the dorsal bone polygons and the dorsal cartilage triangle. Utilization of the aforementioned techniques enables manipulation of the surface aesthetic polygons, facilitating reconstruction of proportions and aesthetic subunits associated with an attractive nose.

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