The achievement of successful results in rhinoplasty may require the use of autografts, homografts, or alloplastic materials. Among the alloplasts, Dacron is an easily handled and manipulated synthetic material, readily applicable to nasal augmentation. The following represents the indications, surgical technique, outcome results, and analysis of our experience with Dacron mesh implants to the nasal tip, dorsum, and lateral walls in 136 patients.

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**PATIENTS AND METHODS**

**PATIENTS**

A retrospective analysis was performed, reviewing the results in 136 patients who underwent rhinoplasty with augmentation using Dacron implants. The indications for dorsum augmentation were a deep nasofrontal angle, a saddle deformity of the dorsum, or a depressed supratip area. Dorsal saddle deformity was the most common indication of dorsal correction.

Indications for tip augmentation were previously detailed. The 2 most common indications were a recessed tip and a wide tip.

The implant may also be used in the lateral wall to augment a depression, typically in cases of side-to-side nasal pyramid deviation.

All patients included in this study were asked several months postoperatively to rate their degree of satisfaction with the cosmetic result. The results were graded as very happy (n=68), happy (n=59), satisfied (n=4), and dissatisfied (n=5). The surgeon, at that same time, rated his own assessment of the aesthetic result. The different grades were very good (n=64), good (n=40), satisfactory (n=24), and unsatisfactory (n=8).

**TECHNIQUE**

**Tip Augmentation**

The technique used for tip implantation was previously described in detail by one of us (N.F.). Several critical points and some minor modifications will be emphasized. The fabric material (Cooley) is first folded onto itself to form a pad that is 2 to 8 layers thick and approximately 1 cm in width (from left to right) and 8 mm in height (from superior to inferior). The thickness of each layer is approximately 0.5 mm.

We present herein our experience in using Dacron alloplastic materials, mostly the fabric form, to augment and shape the tip, dorsum, and lateral walls in 136 patients undergoing rhinoplasty.

**RESULTS**

This series consisted of 92 women and 44 men, for a male-female ratio of 1:2.1. The mean ± SD age of the patients was 26.5 ± 7.5 years for men and 28.9 ± 9.4 years for women. All rhinoplasties were performed by the same surgeon (N.F.). In 88 (65%) of the 136 procedures, only the tip was augmented, while in 45 (33%) of the patients, the tip and the dorsum or lateral walls were augmented. In 3 instances (2%), Dacron was used on the dorsum only.

All patients were prescribed intraoperative antibiotics: intravenous cefazolin, 1 g, when an allergy to penicillin was ruled out or intravenous erythromycin in the cases of penicillin allergy. All patients were treated with oral antibiotics (such as erythromycin) for 1 week postoperatively for further prophylactic coverage.

The follow-up ranged from 7 months to 12 years (average, 37 months). The same operating surgeon (N.F.) performed the follow-up and assessment. Figures 4, 5, 6, 7, 8, 9, and 10 show examples of preoperative and postoperative results of Dacron implantations in various patients (lateral wall implants in Figure 4; dorsum and supratip implants in Figure 5; implants in a patient who underwent revision rhinoplasty in Figure 6; dorsal implant thickest at the nasofrontal angle superiorly in Figure 7; dorsal implant of equal thickness in Figure 8; tip implant only, representing the most common implant indication, in Figure 9; and long-term results in Figure 10).

The most significant complication was infection, which occurred in 9 (6.6%) of the patients. In all cases, the patient was immediately given oral antibiotics on diagnosis of the infection, and the implant was removed under local anesthesia as soon as possible. Removal of the implant was always performed without difficulty because there was little tissue infiltration or fibrous attachment in all of the patients with infection. In the case of a tip implant, a curved mosquito clamp is used to retrieve the implant through a small rim incision. In the case of a dorsal or lateral wall implant infection, the same technique is used through an intercartilaginous incision, but more dissection is required. It is important to accurately count the number of layers removed to ensure complete removal of the implant.

Ten implants were removed in these 9 patients. Eight were tip implants, and 2 were dorsal implants. In a single
of the nose along the midline (Figure 2). In the event the dorsal depression is deeper on one area (typically the middle of the dorsum at the level of the rhinion), a third mark is placed on the skin at that site to identify the area of maximum implant thickness. In general, the length of the implant varies from 2.5 to 3.5 cm, the width from 8 to 10 mm, and the thickness from 2 to 6 layers (1-3 mm). In some instances, the thickness may be greater than 6 layers. The implant may be uniform in thickness or may have an area of greater thickness, as previously indicated. The implant is then shaped in the following manner: the upper and lower ends of the implant are made triangular to ensure a gradual tapering of the implant ends. This avoids an abrupt step deformity after the swelling subsides postoperatively. Also, the implant sides, namely, the left and right borders, are tapered (angled) for the same purpose. If one area of the implant (eg, the central third) is thicker than the rest, a second implant is calculated, measured, and tapered like the first main implant. The shorter implant is then placed under the longer one, and an additional through-and-through catgut suture is used to attach both implants together.

If the dorsal dissection has not been completed, a 1.5-cm incision is made on the medial end of the right intercartilaginous incision at the area of the septal angle (Figure 2). A subcutaneous or supraperichondrial supraperiosteal pocket is dissected along the dorsum. The layers of the prepared dorsal implant are usually sutured about the center or at both ends with 4-0 chromic transfix sutures to hold the layers together (Figure 2). The implant is then placed between the 2 sides of an angled nasal bayonet forceps, ensuring that the superior end of the implant is exactly at the closed tip of the angled forceps. An Aufricht dorsal retractor is used to elevate the dorsal nasal skin, while a curved mosquito clamp is used to retrieve and pull down on the lower edge of the intercartilaginous incision for better entry (Figure 3). The angled forceps embracing the implant is then introduced slowly within the dorsal skin pocket, sliding against the Aufricht elevator (rather than against the dorsum), until it reaches the upper mark on the nasal skin. The Aufricht retractor is then moved slowly backward and removed. The fingers of the left hand are placed gently on either side of the implant. The angled forceps is opened widely and then slowly retraced backwards, using a gentle rocking motion to avoid implant retraction or displacement during this maneuver. The incision is then inspected to ensure that the lower end of the implant is positioned at least 4 mm away from the closure site. A single 4-0 chromic suture is then used to close the incision.

Lateral Wall Augmentation

An incision is made through one or both intercartilaginous folds, depending on whether the depression is unilateral or bilateral. The implant marking, preparation, and insertion are similar to that described for the dorsum. However, the implant is typically much thinner, varying between 1 and 2 layers (0.5-1.0 mm). For lateral wall augmentation, 50% undercorrection is the rule, as the slightest overcorrection will be extremely noticeable a few months postoperatively. The shape is again triangular and tapered if more than one layer is used.

In rare cases, when the lateral wall depression extends inferiorly beyond the lower border of the upper lateral cartilage, the access incision may be made intracartilaginous through the alar cartilage. This is because the incision to the pocket has to be at least 4 mm inferior to the implant.

COMMENT

Dacron fabric allografts are among the myriad of options available in rhinoplastic surgery. Although potential postoperative infection is a disadvantage, Dacron fabric implants are particularly desirable to use in many cases of augmentation rhinoplasty. In terms of the aesthetic result, they have several advantages, the most important of which is having an impressive natural appearance and feel that are hard to detect by either visual examination or manual palpation. They display no tendencies for curling or resorption over time and are unlikely to un-
dergo displacement. In our series, no cases of resorption or implant distortion were observed. In addition, there is no donor site morbidity. Dacron fabric can be molded to assume any shape or thickness required, providing a controllable and smooth contour. The amount of available material is unlimited. Decreased surgical time contributes to lower morbidity and lower cost. Finally, Dacron has been used extensively as a cardiovascular implant and has an excellent long-term record.12-17

Other implantable materials commonly used have similar advantages, but certain drawbacks make them less desirable. Silastic, for example, a silicone rubber, has a firm consistency, therefore tending to feel like a foreign body under the skin. Also, it lacks pores, impeding tissue ingrowth and possibly contributing to implant displacement. Its surface is slippery, which may lead to malpositioning and which makes it hard to handle intraoperatively. Gore-Tex, which has been used in nasal augmentation,6-8 also tends to be slippery, causing possible displacement in the initial postoperative period, before tissue ingrowth has taken place. In addition, Gore-Tex has a whitish color, which may become visible externally, particularly in thin-skinned individuals and particularly in the long term after postoperative edema has subsided.

Dacron is not without its drawbacks, the most significant of which is infection.1 Others include asymmetry and incorrect implant volume, both mostly related to the surgeon’s experience using the material. This experience is quickly acquired if the guidelines suggested earlier in this article, regarding the implant’s thickness range, shape, tapered edges, access incision, and insertion technique, are vigorously followed. The incision needs to be large enough (1.5 cm) to allow good exposure, dissection of a pocket, and easy implant introduction. It should be closed loosely to allow any serous discharge or bleeding to drain, rather than remain confined within the pocket and progress to abscess formation. The pocket needs to be approximately 50% larger than the size of the implant because it will eventually contract. If it is not sufficiently large, it will result in subsequent implant infection or extrusion.

Our complication rate of infection is comparable to previously reported rates of 4% to 9%.4,7 However, this drawback is tempered by the many advantages associated with the use of this material. The high cosmetic reliability and quality of the result are often understated in the literature. Although cartilage grafts are rarely infected, they have cosmetic problems, including resorption, displacement, curling, and sharp edges. The longer the postoperative follow-up, the more evident some of these problems will become, especially those related to curling and sharp edges and those in medium- to thin-skinned patients.
Figure 4. A and B, Preoperative views of a 29-year-old man with a narrow bony bridge and concave upper lateral walls more on the left side than on the right, a recessed upper dorsum, thick redundant skin at the supratip and tip areas, and a drooping nasal tip. C and D, Postoperative result 2 years 4 months following a rhinoplasty with lateral wall implants (just 1 layer on the right and 2 on the left) and dorsal and tip implants.

Figure 5. A and B, Preoperative views of a 29-year-old woman with a low dorsum and thick skin at the tip and supratip. C and D, Postoperative results 11 months following rhinoplasty with a dorsal implant thickest at the supratip area because of a resistant skin concavity at that area. A tip implant was also used.
Figure 6. A and B, Preoperative photographs of a 20-year-old man with a history of 3 previous septorhinoplasties. He presented with a turned-up asymmetrical tip, a recessed dorsum, and lateral wall depressions, more obvious on the left. C and D, Postoperative results 7 years 2 months following a revision rhinoplasty with dorsal, tip, and left lateral wall Dacron (Ethicon Inc, Somerville, NJ) implants.

Figure 7. A and B, Preoperative photograph of a 33-year-old man with a recessed ill-defined nasal tip, a low upper dorsum, and very thick nasal skin. C and D, Postoperative results 2 years 10 months following a rhinoplasty with a dorsal implant (thicker at the root of the nose) and a nasal tip implant.
Figure 8. A and B, Preoperative photographs of a 27-year-old man with a projecting tip and a low dorsum. C and D, Postoperative results 12 months following a rhinoplasty with a dorsal implant of uniform thickness and a tip implant.

Figure 9. A and B, Preoperative views of a 22-year-old woman who is a typical example of a nose surgery candidate with a dorsal hump and a somewhat wide nasal tip. C and D, Postoperative photographs 15 months after a regular rhinoplasty combined with the placement of a tip implant to achieve a well-defined yet natural-looking nasal tip. This case is a typical example of the use of the Dacron (Ethicon Inc, Somerville, NJ) nasal tip implant, which is more often used in the nasal tip than in the dorsum or lateral walls.
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REFERENCES


Figure 10. A and B, Preoperative views of a 28-year-old woman with a low dorsum and a prominent and very boxy nasal tip. C and D, Very long-term postoperative result 11 years 2 months after the use of Dacron (Ethicon Inc, Somerville, NJ) implants in the dorsum and tip areas.