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VIEWPOINT

Facilitated Alar Rim Graft Placement with an Ophthalmic Slit Blade

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Alar rim grafts are a direct and popular way to control alar rim contour, which has an important role in rhinoplasty aesthetics and function. Initially described by Troell et al.[1] and later popularized by Guyuron[2] and Rohrich et al.,[3] alar rim grafts are now used for a variety of indications in both primary and revision rhinoplasties, including concave, collapsed, flared, mildly retracted, or asymmetric rims, or weak or malpositioned lateral crura.

We describe a novel technique for placing alar rim grafts that is both technically easier and more accurate using an ophthalmic slit blade, a tool typically used to incise the cornea. In our technique, a skin hook is placed on the anterior end of the nostril and the hook is held by the index finger and thumb. The middle finger of the same hand everts and stabilizes the alar rim. A 3.0 mm angled slit knife is then introduced through the existing infracartilaginous incision and pushed in from the lateral dome to the alar base to develop a subcutaneous pocket (**see figure, Supplemental Digital Content 1**, which displays a 3.0 mm angled slit knife as it is introduced through the edge of the existing infracartilaginous incision, ***http://links.lww.com/PRSGO/A751***; **see figure, Supplemental Digital Content 2**, which displays how the knife is pushed in from the lateral dome to the alar base to develop a subcutaneous pocket, ***http://links.lww.com/PRSGO/A752***).

The knife is withdrawn, and the alar rim graft then slid into the pocket using an Adson-Brown forceps (**see figure, Supplemental Digital Content 3**, which displays the precarved alar rim graft as it is slide into the dissected pocket using an Adson-Brown forceps, ***http://links.lww.com/PRSGO/A753***; **see figure, Supplemental Digital Content 4**, which displays how the alar rim graft has been placed and fits in the pocket securely, ***http://links.lww.com/PRSGO/A754***). Any protruding cartilage is trimmed and/or morsalized. The graft usually does not require suture fixation because of the accurately dissected pocket. The infracartilaginous incision is closed as per routine (**see video, Supplemental Digital Content 5**, which displays our intraoperative technique of alar rim graft placement, ***http://links.lww.com/PRSGO/A755***). Figure 1 show pre- and postoperative (6 weeks) photographs of the same patient after having placement of alar rim grafts with our technique.

Fig. 1. Pre- and postoperative basal views (6 weeks) of the same patient after having placement of alar rim grafts using the ophthalmic slit blade technique.

Our technique features numerous advantages. First, the slit knife allows for definitive control of the size of the pocket. The 3.0 mm blade accurately creates a 3 mm pocket, which can then snugly fit a same-sized graft and negates the need for suture stabilization of it. If smaller grafts are desired, the knife also comes in sizes ranging from 1–3.5 mm. Second, the straight leading edge of the blade allows for easy control of the vector of pocket dissection, which can be made parallel to the alar rims or oriented cephalad heading toward the alar base, to each surgeon's preference. Third, the angled nature of the blade (45°) allows for pocket dissection under direct visualization and with a simple pushing motion, rather than spreading with fine scissors or mosquitoes, which can be more tedious, time-consuming, and excessively traumatic in such a delicate area.

The senior author's preference (A.G.) is to use the Alcon (Forth Worth, Tex.) 3.0 mm Angled Slit Knife, although other ophthalmic blades presumably perform the same function (**see figure, Supplemental Digital Content 6**, which displays a manufacturer box of the Alcon angled slit knife, ***http://links.lww.com/PRSGO/A756***). The slit knife is a ready-to-use, 1-time use tool that can be used for both sides. The cost for a box of

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6 is $75 USD translating to a unit cost of $12.50 USD, which is certainly affordable. We are excited to share our technique and hope it is of interest and benefit to rhinoplasty surgeons worldwide.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article. The Article Processing Charge was paid for by the authors.

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