

[Home](#) > [May 2010 - Volume 125 - Issue 5](#) > Reply

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Letters

Reply

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Sir:

Congratulations to Dr. Mandrekas and associates on the successful example of nasal reconstruction in a child. The beautiful result is testimony to having made all the right decisions. I am especially pleased that techniques of open rhinoplasty were used, as I have also used these in my practice. These techniques are useful when the anterior nasal septum is present. In patients where the anterior septum is missing, other more complex techniques for support of the reconstructed nose are required.

The congenital hemangioma seen in Dr. Mandrekas' patient had undergone involution, *not* necrosis, so that the entire integument of the nose was still present. The patient possessed a slightly bulky nose, but not a horribly deformed one. Therefore, her operations were rightly postponed until ages 9 and 16 years. In many such cases, the congenital hemangioma has undergone frank necrosis and fallen away as a result of autolytic débridement. Alternatively, a surgeon has, with good intention, excised the tumor mechanically and with it a part of the underlying normal, natural nose. The resulting nasal deformity can be quite severe, which may in turn have negative and lasting psychological and social repercussions. In these instances, it is a mistake to allow a child to grow up without correction of the nasal deformity. Reconstruction performed after a child has grown is done too late to avoid the social isolation and stigma of a facial deformity when school attendance begins. It is my firm belief that a severe nasal deformity should be corrected through staged procedures beginning at age 3.5 years. The child can then enter school at age 5 years appearing normal and possessing the confidence that such an appearance bestows. Skin grafts, composite grafts, and free microvascular flaps may temper or mute a severe deformity. However, only a vertical forehead flap with a cartilage graft framework eradicates it. Had I seen the 9-year-old patient presented in my article at age 3.5 years, I would have performed a forehead flap reconstruction at that time.

Each patient is an individual who presents with unique challenges. In children especially, one must consider the negative social impact a marked deformity may have on the child and their parents and siblings. Patients often suffer from an overwhelming sense of shame, and the formation of a well-adjusted personality and appropriate social skills may be inhibited. In an early article on the subject, Dr.

Caspar M. Epstein expresses the core of the problem:

“There are three important psychological effects of deformity: (1) inferiority and shame, (2) modification of self-expression, and (3) antisocial tendencies. Children are notoriously observant of the unusual, and are cruel; they have no inhibitions. A great deal of undue attention is invariably directed to any cosmetic abnormality. There is no attempt on the part of a child to ... refrain from ridiculing.”¹

Dr. Epstein goes on to state that children with facial deformities are often shunned or forced into an inferior social status.¹ Thus, in the pediatric patient population, appropriately applied and well-timed aesthetic reconstructive surgical intervention is of paramount importance. It is our professional duty to familiarize ourselves with and use all of the tools at our disposal to, as Gaspare Tagliacozzi noted in 1597, “bring back, refashion, and restore to wholeness the features that nature gave but chance destroyed.”

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[Back to Top](#) | [Article Outline](#)

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[Back to Top](#) | [Article Outline](#)