The Revision Rhinoplasty Consult: The Art of Managing Expectations.

Benjamin C. Marcus, MD¹

¹Division of Otolaryngology, University of Wisconsin, Madison, Wisconsin


Abstract

Rhinoplasty is widely acknowledged to be a challenging operation. The success of the operation has long been measured in anecdotal ways. As the surgeon—do I think the outcome is good? Does the patient tell me they are happy? At hand is an obvious issue with patients sometimes not returning to their original doctor. Other times they may have minor concerns that take minimal effort to correct. Does that constitute a revision? In most circles, the ultimate definition of revision rhinoplasty is a return to surgery with the intent to correct a functional or aesthetic concern that arose after the original procedure.

Keywords
- rhinoplasty
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The Truth about Surgery

Rhinoplasty is widely acknowledged to be a challenging operation. The success of the operation has long been measured in anecdotal ways. As the surgeon—do I think the outcome is good? Does the patient tell me they are happy? At hand is an obvious issue with patients sometimes not returning to their original doctor. Other times they may have minor concerns that take minimal effort to correct. Does that constitute a revision? In most circles, the ultimate definition of revision rhinoplasty is a return to surgery with the intent to correct a functional or aesthetic concern that arose after the original procedure.

Revision rates can be hard to quantify as well because they are self-reported. The rhinoplasty surgeon may be willfully or subconsciously underreporting their cases that require revision. There have been a variety of studies that have tried to determine a rate of revision. Many were single surgeon, others were limited by power. The rate from this group varied from 3 to 15 or 25% depending on the study. This high range was indicative of somewhat disparate pools of data.
A very well-done study by Spataro et al. looked at the Healthcare Cost and Utilization Project state databases. Three major states were surveyed: New York, Florida, and California. They were able to capture an enormous amount of patient data and had more than 175,000 patients who had undergone septorhinoplasty from 2005 to 2012. With this very high-powered study, they were able to demonstrate an overall revision rate of approximately 3%. The rate jumped to 11% for secondary surgery. Patients with cosmetic concerns and congenital deformities also had higher rates similar to secondary surgery. One element of this data that is confounding is the stark separation of cosmetic and functional cases. Many patients in our practice have overlapping goals. A successful functional surgery with resolution of the breathing concerns but a small cosmetic blemish might qualify for revision even though the original intent of the surgery was met and/or exceeded. This is the reality of modern patient care where patient satisfaction is paramount.

Another larger study looking at variations in the technique observed a group of approximately 1,700 patients who underwent open, endonasal, or hybrid procedures and found that the revision rate was around 4% regardless of the techniques used.

Another method to better report patient outcomes is the use of the patient-reported outcome measures (PROMs), which include validated questionnaires like the NOSE, FACE-Q, and others that allow patients to rate their outcome in a meaningful and reliable fashion. In the era of modern technology, it is necessary that the patients fill out their PROM survey in a private or online setting. This would naturally increase the validity and honesty of their responses. One of the new PROMs is the Standardized Cosmesis and Health Nasal Outcomes Survey by Most at Stanford (personal communication). This PROM allows the simultaneous and validated capture of both the aesthetic and functional nasal data. This is certainly an exciting development as both should be equally important in modern rhinoplasty. There are very few patients who want to look better and are willing to sacrifice nasal function. Improvement in nasal breathing is important, but not at the cost of an aesthetically displeasing nose.

Identification of the Problems Physical and Mental

When evaluating a patient for revision surgery, we need to pay equal attention to the physical examination of the nose as well as the emotional state of the patient. In case of the physical examination, we start by determining what was done in the primary surgery. Patients are often unclear about what was performed. Operative notes if available are helpful but may not tell the whole story. In truth, the primary surgeon is unlikely to dictate the potential mistakes that were made. Worse, the note may minimize destructive maneuvers that were performed, leading to a false sense of confidence to the secondary surgeon.

The best tool to evaluate the revision nose is careful physical examination. With our eyes, hands, and perhaps an endoscope, we should be able to determine the structural integrity as well as the weaknesses in the nose. Our eye is not enough to classify the aesthetic concerns that are apparent on first pass. Rather, we need to completely catalog the “state of the nose.” We recommend that each and every nose be evaluated in the same fashion. We always start with a series of PROMs. A subjective functional evaluation provides an essential foundation. Next, a PROM that evaluated satisfaction with cosmetic outcome can be very useful. The remainder of the examination is a process of cataloging. Was the nose a case of overoperation? Was the nose undertreated? While many noses do not fall neatly into these categories, the concept is very useful when applied to each of the subunits of the nose. For example, a nasal dorsum may be overresected while the nasal tip may be undertreated. In either case, applying these concepts helps us communicate to the patient what we are observing in their nose. Furthermore, it helps frame the complicated and varied surgical plan that is often a result of our analysis when completed. Patients appear to be more accepting of additional graft harvest (rib, ear) when they understand that their cartilage has been depleted.

It is also very essential to help the patient understand the interrelationship between the functional and cosmetic aspects of their case. In our experience, almost all revision cases have some element of functional compromise. Modern rhinoplasty has armed us with many tools that can improve the airway without distorting cosmesis, but some changes may be necessary to meet the goal of improved function and appearance. I have often found this subject to be particularly intricate. Some patients are willing to sacrifice nasal function for their perception of beauty. As ethical surgeons, I believe we must tread a very careful line to provide attractive noses that work.

The Concept of Fit

Because revision rhinoplasty often starts with a fractured relationship, the new provider must tread very carefully when initiating the doctor–patient relationship. We cannot to be too eager to please, we certainly should not disparage the previous surgeon, and, above all, we should be honest in our communication. A low pressure, honest assessment of the patient will determine in many ways how realistic the expectations of the patient are. We can please many prospective patients with our successful case photos, our accolades of speaking at meetings, or by how busy we are. If we bring humility and an open ear to the session and offer honest but thoughtful advice the patient, it will be much more likely that the patient will connect with us in a lasting fashion and with a better understanding of what we can offer.

We often forget that as we consult with patients we are evaluating them just as much as they are evaluating us. While they ponder our skill, bedside manner, and past track record, they are taking stock of the potential to have a productive relationship with us. As a surgeon, we want to operate and our livelihood depends on it. That being said, we need to be able to pick the patients that are best suited for our
demands, philosophy, and skills. Constantinides offered the use of R-questions as a simple tool to help determine the fit. If the person answers the “R-Factor Question,” an opportunity for a relationship is created. In answering, he or she demonstrates both trust in a potential relationship and a clear desire for a bigger and better future. The answer will always be given in terms of specific goals, objectives, improvements, changes, and solutions. A person’s answer to the R-Factor Question clearly defines who his or her “Future-Based Self” is, and this knowledge enables you to begin creating value in the relationship. Once we know where a person wants to go in life, we can begin assisting his or her progress by contributing our abilities and resources.3

Tools for Education

One of the critical tasks of a revision rhinoplasty consultation is establishing the right expectation for patient outcomes. Many patients will idealize the possible outcome. Even with careful and specific explanation by the consultant, we can never know exactly what our potential patient is imaging. While this is important for all rhinoplasty procedures, it is especially critical for revision surgery where outcomes and strategies may be limited due to the prior work performed. In our practice, we routinely use three-dimensional imaging (Vectra, Canfield Scientific, Inc.) and we stress that the imaging is not an exact representation of the surgical outcome but a sketch of sorts to get them to understand what we are thinking. This is a somewhat prevalent practice in the modern era.4 Singh and Pearlman did a large survey of 1,200 facial plastic surgeons. Their response rate was acceptable and they found that 63% of the surgeons used computer imaging for rhinoplasty consultations (both primary and revision). When computer imaging was used, over 90% of the surgeons performed image morphing themselves. I think this is a critical aspect of using computer imaging. We never want to overpromise with the imaging. Rather, it is the philosophy of our group to “underperform” in the imaging process so that ideally the surgical product is better than the imaged product. The opposite invites further disappointment and perceived failure. If a patient is not satisfied with a very good rendering of their nose, then perhaps they are not a good fit for your practice.

Another important subject to carefully broach and evaluate is the presence of body dysmorphic disorder (BDD). While many of us feel that we see patients with BDD every now and then—the prevalence may be quite a bit higher than we acknowledge. In a recent study by Veale et al,5 the presence of BDD was nearly 20% in prospective rhinoplasty patients, as compared with the general society rate of 1.9%. Even patients pursuing other cosmetic procedures had a rate of 13%. Clearly, the majority of us are not screening for BDD appropriately or we would be turning away nearly 20% of our consults. While BDD does not automatically exclude a patient from revision rhinoplasty, it necessitates an orderly process of identification, counseling, and progress before pursuing additional surgery.

Classic Risk versus Benefit Analysis

At the end of the day, it is important to remember that we have the ultimate decision-making power when it comes to accepting a patient as a surgical candidate. Rhinoplasty is not cancer surgery. It is at its essence an elective procedure. With that in mind, we must carefully balance the following factors:

1. Are the patient’s expectations reasonable?
2. Are their goals achievable in our hands?
3. Is the patient emotionally ready to proceed with revision surgery?
4. Is the patient a good “fit” for our practice and style of care?

If we can say yes to the criteria above, we have a high likelihood of being able to help the patient and form a healthy doctor–patient relationship. There are few joys as great as achieving a good result for a revision rhinoplasty patient. By restoring form and function, we not only rehabilitate the nose but the patient and their well-being as well.

References

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