

## LETTER TO THE EDITOR

### Letter to the Editor in Chief

To: **Prof. Dr. Codrut Sarafoleanu, MD**

Editor in Chief of the **Romanian Journal of Rhinology**

Zagreb, May 21st, 2019

**D**ear Editor in Chief, hereby you will find some words as a comment on the article published in the latest issue of the RJR entitled „*Comparison results of nasal septum suturing and nasal packing following septoplasty*“ by Ali Asghar Peyvandi and al., published on the pages 97-99, Volume 9, No 34, April-June 2019.

First of all, I wonder whether Miss Oana Topalescu had the opportunity to see this paper, since even in the title there are linguistic errors or at least wrong syntaxes. The title is not informative and clear enough as it should be.

In the section **Material and Methods**, the authors do not at all offer a word on the essential issue that is they do not mention what were exactly the types of the septal deformities they have operated on. Types 1, 2, 3 and 4 are in principle quite easy to operate on, certainly under the terms that the surgeon is an experienced person. But types 5 and 6, and in particular type 7 (particularly if it consists, besides some of the vertical deformities like types 1,2,3 or 4, also of at least one the additional horizontal deformities like types 5 and 6). Type 6 is particularly demanding septal surgery because of the elevating the mucoperiosteal and mucoperichondral flap from the typical septal groove, so characteristic for the type 6. The mucosa that covers this region is in rule thin and fragile, and lacerations can happen even in very experienced hands! The same goes for the type 5 which is located very deep in the nasal cavity and thus is not easily reachable for the surgery. Lacerations are also very frequent, particularly along the borderline between the upper edge of the vomer and the inferior edge of the perpendicular lamina.

In terms of that, in my mind and according to my

more than 40-yr experience in operating nasal septum, types 5 and 6 are not at all “candidates” for any kind of stitching. There is always a surplus of the mucosa, and the surgeon should adjust them so that they simply overlap each other, and, finally, put some resorbable tissue over the place of reparation, leave it alone for seven days, protected by gently inserted splits or other kind of light packing as to avoid any unnecessary pressure to the incriminated area. And now, do we have to speak about stitching after “septoplasty”? No, not at all. Septal surgery is in most of the cases demanding surgery which requires surgical skill and theoretical knowledge. It is not possible to scientifically analyse the success rate of a cohort of patients that underwent septal surgery without saying essential data: the percentage of the particular types of septal deformities in the cohort. The data must be clear and overall, they must be repeatable. None can repeat the same experiment if there are no essential data to enter the study. In this very case it goes for classification of the nasal septal deformities. Otherwise, none in the world can imagine how the septum looked like before the surgery. This is also dangerous nowadays when looking at it from the aspect of the forensic medicine.

Finally, some intraoperative images are terribly missing since it obviously goes for the trans-septal reverse suturing, not simple suturing of some laceration at one side of the nasal septal mucosa only. In addition, no one word has been said about on which side of the septum will be placed the surgical knot. This is extremely important for the surgeon who usually do not use this technique, and particularly for the younger. One should keep in mind that the surgical knots, even small and gently placed, could provoke crusting around them, some

bleeding and, because of that, nasal breathing disorders in the early postoperative period.

No word has been said on what type of the surgical thread should be used in suturing nasal septum, be it by means of trans-septal reverse suturing as to minimize the possibility of development of the septal hematoma postoperatively and to keep nasal septum in desired, straight position, or in cases of reparation of the unilateral lacerations. One should know that it always goes for the resorbable thread, so no further interventions in the nose are required after the septal surgery. In cases of trans-septal reverse suturing, the knot must be placed on the opposite side of the previous septal convexity, the distance between the entering holes of the needle carrying the thread should be minimally one centimetre far away from the hole from which the needle comes back! Otherwise, particularly in cases of un-experienced hands, the suture, if placed under the tension, could provoke unexpected longitudinal lesion of the septal mucosa bilaterally, resulting in permanent septal defect. Because of its position, this type of septal defect, regardless how small in diameter it could be, can become really great surgical problem in attempt to close it permanently! So, there is a bunch of possible risks in trans-septal suturing of the nasal septum and because of that this procedure should be done with a great attention and wisely. All the facts mentioned above belong to necessary data that should be offered to the reader of the rhinologic journal and to all those who want to try the same technique and to get by time their own results.

At the end, I have to stress out once again the importance of differentiating between two terms: 1. *Septal deviation* and 2. *Septal deformity*.

Septal deviation means, in fact, that the nasal septum is still straight, with no crests, bulging or whatsoever kind of morphologic changes in its shape, but has changed its direction, position from the medio-sagittal line by some degrees to the right or left. Therefore, this exists in reality whenever we are dealing with misalignment of the whole nose, i.e. the nasal pyramid is nice but unusually positioned, i.e. declined from the medio-sagittal plane to the left or right sagittal plane. This is called oblique nose. As stated before, septal structures are in rule normal and do not require any surgical correction. On the contrary, when the nasal septum has changed its form because of whichever reason (trauma, heredity) the term septal deformity should be strictly used.

Furthermore, once we want to present our results, thoughts or whichever item regarding nasal septum, we must speak an international, common language and use some of the already established and well-known classifications of the nasal septal deformities (Mladina, Rao, Guyuron, Baumann, for instance). Otherwise, we simply cannot understand each other, and this is great pity in the year 2019. It looks we are blind and unable to recognize specific types of septal deformities that in reality exist. They are among us.

*With all my respect,  
Prof. Dr. Ranko Mladina*

