

CURRICULUM VITAE

Name: Ji Yun Choi, M.D.

Education

1998 : M.D., Chosun University College of Medicine, Gwangju, Korea

2008 : Ph.D., Inha University Postgraduate School, Incheon, Korea

Postgraduate Training

Feb, 2012 – Jan, 2014 : Fellowship as a visiting professor

UC Davis medical center in Sacramento, CA, USA

May. 1998 – Feb. 1999 : Rotating Internship
Chosun University Hospital, Gwangju, Korea

Mar. 1999 – Feb. 2003 : Residency
Department of Otorhinolaryngology
Chosun University Hospital, Gwangju, Korea

Positions Held & Faculty Appointment

March. 2003 – Feb. 2005 : Faculty
Department of Otorhinolaryngology
Hyesung Hospital, Buan, Korea

March. 2005 – Feb. 2007: Faculty
Shimmian rhinoplasty Clinic, Seoul, Korea

March. 2007 – Feb. 2009 Full-time Lecturer
Department of Otorhinolaryngology
Chosun University College of Medicine, Gwangju, Korea

March. 2009 – Feb. 2012 : Assistant Professor
Department of Otorhinolaryngology
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Feb. 2012 – Jan. 2014 : **Clinical Fellow**
Department of Facial Plastic & Reconstructive Surgery

Jan. 2014 – Present : **UC Davis Medical Center, Sacramento, USA**
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Licensure and Certification

Licensed to Practice Medicine in Korea, 1998

Korean Board of Otolaryngology, 2003

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I hereby declare that the above statement is true and correct in every respect to the best of my knowledge.

Ji Yun Choi, M.D.

Management of nasal deformities in Asian : How I do it

Ji Yun Choi, MD, PhD

Chosun University Hospital & College of Medicine

Principles for the surgical correction of the deviated nose

1. All deviated structures must be exposed through the open rhinoplasty approach especially high septal deviation exists due to the precise diagnosis and treatment
2. All deviated part of the mucoperichondrial attachment to the septum must be released
3. Deviated septum must be straightened while maintaining an at least 10mm caudal and dorsal strut
4. We should restore long term support with buttressing caudal septal batten or dorsal spreader cartilage grafts
5. Hypertrophied inferior turbinate should be treated
6. Precisely planned and executed external percutaneous osteotomies should be performed
7. Accurate preoperative planning and diagnosis are essential to successful outcome

Approach

1. Endonasal approach
2. Open rhinoplasty approach : wide exposure and accurate diagnosis

Surgical approaches to cartilaginous septal deformity

The surgical approach to revising a cartilaginous septal deformity can be performed through a “closed” incision or through a standard open rhinoplastic approach.

“Swinging Door” technique

Another closed technique introduced by Metzenbaum is called the “swinging door” in which a caudally deviated septum is released from the nasal spine and maxillary crest, adjustments are made to any excess of cartilage along the nasal floor, and the ventral caudal septum is “swung” to the other side of the nasal spine and sewn into place. This technique can be very effective for

the ventral aspect of the caudal septum but does not change the inherent twist or bow of the septum. The nasal tip may remain deviated, and again, resupporting the nasal tip must be considered in this procedure.

Open approach

Due to the limitations of the closed approaches and the generally greater complexity in revising the cartilaginous septum, the authors primarily use the open approach. Most of the revision they see involve the caudal septum, and the authors commonly add spreader graft or make attempts to straighten the nose, which are accomplished with greater facility by the open approach. A standard inverted V transcolumellar incision is made, and dissection to expose the upper and lower lateral cartilage is completed. Meticulous dissection ensures to ensure exposure of the cartilage in the submucoperichondrial plane. Access to the complete dorsal and ventral aspects of the caudal septum and nasal spine is achieved. The mucoperichondria of both sides are dissected to release all forces of scarring and contraction. This is a tedious dissection but gives excellent visualization and often allow simultaneous repair of perforations that may have resulted from primary septoplasty.

Reinforcement of L-strut

Any deviated portion of the quadrangular cartilage not occupying the L strut area are removed and maintained for grafting purposes, Reinforcing graft of harvested septal cartilage is suture across the deviation to maintain the correction and add support. The preferable graft is septal cartilage, but autologous rib, thin perpendicular plate of the ethmoid bone(PPE), donor rib, and Porex(Porex Corporation, Newman, Georgia) may also be used.

Extracorporeal septoplasty

A more common presentation is the patient who has a poorly supported nose and virtually no straight septal cartilage. In this case, extracorporeal septoplasty is advocated. This method involves removal of most of the septal cartilage after making careful measurements of the appropriate dorsal length and caudal height. A portion of the dorsal septum at the junction of the nasal bone(keystone area) is left intact to have an area to which to sew. The harvested cartilage is then carved and fashioned using suture into an adequate L strut and introduced back into the nose, securing it to the keystone area and upper lateral cartilage. The configuration is made such that the caudal strut also functions as a columellar strut and is sewn to the nasal spine in addition to the medial crus of the lower lateral cartilage for tip support.

Spreader graft

- Cartilage interposed between septum and upper lateral cartilages with the membrane released inferiorly
- Indication : camouflage effect, widening the nasal dorsum, improve the compromised nasal valve, straightening the septal strut
- Graft material : septal cartilage, ethmoid bone, auricular cartilage
- Unilateral or bilateral
- Fixation graft material with bilateral upper lateral cartilage by absorbable material