**Mr Michael Cadier**

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**Consultant in Plastic, Reconstructive & Aesthetic Surgery**

**Treatment for Rhinophyma and Thick Nose Skin**

Rhinophyma is a skin disorder which is characterized by a large, red, bumpy or bulbous nose. The cause is unknown though it is probably a form of severe rosacea. It occurs predominantly in men from the ages of 50 to 70 and can be very distressing. It is frequently thought to be associated with excessive alcohol consumption. This is not true. Some patients may have a mild variant of this with thickening of the nose tip skin and overgrowth of the sebaceous glands. Some patients will have had prior rhinoplasties and remain unhappy about the thickness of the tip. When the skin is thick further rhinoplasties are seldom of benefit.

To correct these problems Mr Cadier undertakes a shaving and dermabrasion technique to reduce the thickness of the nose skin. This can be performed either under local or general anaesthetic. The trade-off is the potential for paling of the skin and the risk of scar formation. For many patients it is appropriate to do a small test patch under local anaesthetic to determine the suitability for the procedure.

**Pre-operative advice.**

In order to optimize the result and minimize the risks a number of factors should be considered. Smokers have a much higher risk of developing complications. It is therefore advised that they should refrain from smoking for ideally four weeks prior to, and four weeks following surgery. Aspirin and related anti-inflammatories (other than those prescribed during the admission) should be avoided for one week before and 48 hours after surgery as these can significantly increase the risk of bleeding. Many supplements (gingko, ginger, turmeric, garlic) have anti-coagulant effects and therefore can increase the risk of bleeding and bruising and should be discontinued for a similar time period. The use of arnica is debatable with no clear evidence to support either its use or its avoidance.

If a patient has an active herpetic lesion or impetigo the procedure will be cancelled until the lesions have been effectively treated. In patients with a history of herpetic lesions or impetigo treatment with antivirals and antibiotics respectively is required. Some patients may benefit from pre-treatment with Retin-A lotion, though anyone who has had Isotretinoin tablet treatment in the past year should avoid this treatment.

Patients who are overweight also have a higher risk of complications. If patients are dieting, they should aim to get to their desired weight pre-operatively. Mr Cadier and his team have the policy that such surgery will only be offered to patients with a Body Mass Index (BMI) of less than 36. The BMI is calculated from the weight and height, and there are many simple tools available on the internet to help perform this calculation. Patients with a BMI of 36 or over have much higher risks both from the surgery and the anaesthetic and the risks therefore potentially outweigh the benefits.

**What happens before the operation?**

At the initial consultation with Mr Cadier after discussing regarding the specific concerns a full medical and surgical history will be obtained. As part of the consultation a psychological assessment is made to ensure that it is appropriate to undertake the surgery, and on occasions the completion of a psychological questionnaire may be required. In all cases Mr Cadier will write to the GP to request a past medical history. Patients may refuse this but need to be aware they are exposing themselves to more risks should they omit or forget some relevant past medical history. Also, in the post-operative period should there be any problems it is important that the GP is aware what has been undertaken in order to be able to offer effective help and advice. At the consultation details regarding the operation, the aims, the limitations, the recovery and the risks will be discussed. Before the operation you will usually attend for a pre-operative nurse led assessment. You may require a blood test. Any significant health problems not previously identified may be discussed with Mr Cadier or the anaesthetist, and a further assessment may be required to determine suitability for the procedure.

At admission you will again be assessed by the nurses and you will be measured for a pair of compression stockings. These are worn to reduce the risk of thrombosis formation and should be worn for a minimum two weeks post-operatively. You will be seen by the anaesthetist prior to surgery and be able to discuss issues pertaining to the anaesthetic and also pain relief in the immediate post-operative period. You will also see Mr Cadier who may make some pre-operative markings and will take photographs for the medical records.

If being undertaken under a local anaesthetic this is done as a walk in, walk out procedure in the outpatient department, with no need for any pre-assessment or any tests.

**The shave procedure.**

This can be undertaken either under local anaesthetic (using topical cream applied 1 hour before and supplemented with injections at the time of surgery) or general anaesthetic especially when being performed at the same time as another procedure. After cleansing of the skin, the area is shaved and sculpted to the provide a desirable shape. The shave procedure may be undertaken as a minor operation in the outpatient department or under general anaesthetic as a day. case Following treatment, a temporary dressing with local anaesthetic will be applied which is removed when the oozing has stopped, and antibiotic ointment applied.

**What to expect after the shave procedure.**

For the first 5-7 days the area should be kept moist by the application of small amounts of antibiotic ointment and Vaseline. A short course of antibiotic tablets may be prescribed. Washing with cold water and simple soap is permitted on a daily basis and any crusty accumulation may be very gently removed. Extensive picking should be avoided as it will predispose to infection and scarring. The area will say red for about 2 weeks, then pinkish for several more weeks. Makeup can usually be applied after 10-14 days. For between 3 and 6 months following the shave procedure sun exposure should be avoided, and a high factor (SPF 30 or greater) should be used on a daily basis. Simple painkillers (Paracetamol and Ibuprofen) may be taken for the first few days though many patients experience minimal discomfort. A sudden increase in pain may be as a result of infection. Patients should return to the hospital for medical review.

**Follow up.**

Patients will usually be offered a follow up at a week in the specialist nurse dressing clinic. Patients will be reviewed by Mr Cadier at a minimum of one and five months in the outpatients. Appointments to see Mr Cadier in the outpatients will be sent via the post.

**Risks and complications.**

The risks include the following:

* Redness and swelling
* Temporary increase in pore size
* Acne like small spots (milia)
* Changes in the skin colour
* Infection
* Scarring including hypertrophic and **keloid** scarring
* Allergic reactions to the ointments/skin preparation
* Psychological distress
* Incomplete correction

If under general anaesthetic the following also apply:

* Deep vein thrombosis and life-threatening pulmonary embolism
* Anaesthetic complications – these will be discussed with you by the anaesthetist before surgery.
* Death

Redness and swelling are normal with the redness fading after several weeks and the swelling usually settling in a few days. The swelling may be associated with an increase in the pore size. Prolonged swelling can occur and may take many weeks to settle – this is an unusual complication. Small white spots can develop whilst the skin is healing, these will disappear by themselves.

The commonest problems following nose shaving procedures are changes in the pigmentation of the skin. In the immediate period patches of over (hyper) pigmentation can occur. This usually results from sun exposure without adequate protection and in most cases will resolve of a few months. Ultimately following all shave and resurfacing procedures, a degree of paling (hypopigmentation) of the skin is inevitable. As a result of these pigment changes this procedure is usually contraindicated in patients with a coloured skin and should be undertaken with caution in patients that do not wear makeup.

Occasionally the areas that have been treated can become infected. When this occurs the pigmentary changes above may be more noticeable and in more severe cases scarring can follow. Patients are therefore advised to avoid excessive touching of the area and the temptation to pick at the area should be resisted. Patients who have a tendency for cold sores may need special precautions to prevent a herpetic eruption. Even without an infective problem skin damage and scarring are rare but recognized complications of the dermabrasion procedure.

Scarring is a well-recognised complication of all skin resurfacing procedures and may range in severity from small red patches to raised red lumpy hypertrophic or keloid scars. Should these occur prompt treatment with massage, and steroid and silicone ointments usually help, and sometimes laser treatment is recommended. Ultimately the scars should settle down though this may take many months or even 1-2 years and will almost certainly lead to pale patches (these are easy to conceal with makeup). Patients frequently underestimate the degree of conspicuous crusting and visibility of the redness in the first ten days. This can be very distressing. However, this is a temporary problem and the treated area will settle down by 7-10 days. Patience is urged. Allergic responses to the skin preparation or the antibiotic ointment may slightly delay the recovery.

Following any surgery under general anaesthetic there is a risk in developing a deep vein thrombosis (DVT). This is a clot in the calf vein of the leg. In itself it may result in pain and swelling. The risk is that should the clot separate from the vein it can move to the lungs resulting in a pulmonary embolism. This is a potentially life-threatening situation. All attempts are made to reduce the risk using compression stockings during and for two weeks after surgery, using pneumatic compression devices on the legs at surgery and in the immediate post-operative period, by encouraging early mobilization, advising patients to stop the combined oral contraceptive pill or Hormone Replacement Therapy (HRT) four weeks prior to surgery, and where it is felt appropriate using injections of blood thinning agents.

All surgical and anaesthetic procedures have risks, and some are life threatening, these include pulmonary embolism, anaphylaxis (severe allergic response to a medication) and adverse drug reactions. Death however remains an extremely rare complication.

Risks and complications will be discussed, and all efforts made to minimize any risks. Patient safety is always our first concern.

When complications do occur, all attempts are made not only to remedy the problem in as speedy a manner as possible but also to optimise the final result. As with all cosmetic surgical procedures undertaken by Mr Cadier, there is a fixed fee policy, which means that no further charges are incurred for the treatment of complications that are identified within 6 months following the initial surgery. Revisional policies for aesthetic concerns have changed and, in most cases, additional fees will be incurred. Patients need to be aware regarding the limitations of surgery and have very realistic expectations about outcomes.

Most patients are very pleased with the result of the treatment. When complications do occur, all attempts are made to remedy the problem in as speedy a manner as possible and to optimize the final result.

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**About your Surgeon:**

A person wearing a suit and tie

Description automatically generatedMichael Cadier was educated at the French Lycée in London, studied at Oxford University and undertook Medicine at St Thomas’ Hospital, London. After training in London, Salisbury and Bristol he became an NHS Consultant in the Supra-regional Plastic Surgery Unit in Salisbury in 1996, becoming Head of this Service in 1999. In his NHS practice he developed a breast reconstruction service in Portsmouth, and in 2000 was appointed as cleft surgeon to the newly established Spires Cleft Centre, for which he also became the first Clinical Director in 2002. He undertook yearly cleft lip and palate Charity missions in rural Pakistan from 1996 to 2009. He has a busy aesthetic surgery private practice along the South Coast, undertaking the full range of aesthetic surgery procedures. He has performed over a thousand facelifts, and over 1500 breast augmentations, with similar numbers for all of the more common aesthetic procedures. In 2015 he became fully private, concentrating solely on aesthetic surgical practice.

He is widely published and lectures and teaches on aesthetic surgery both nationally and internationally. In 2006 he was invited to become an examiner for the FRCS (Plast). He is the Program Director for the South Coast Reconstructive Cosmetic Surgery Fellowship, was part of the first UK delegation in the CEN in cosmetic surgery (European regulation) and chaired the CSIC Royal College committee on Clinical Quality and Outcomes in Cosmetic Surgery.

The British Association of Aesthetic Surgeons (BAAPS) is the leading organization for aesthetic surgery in the UK. He was elected to BAAPS Council in 2006 and was President of BAAPS from 2014 to 2016. One of his key objectives is to ensure that UK plastic surgeons of the future will practice aesthetic surgery to the highest possible standard and with that aim he has helped establish a comprehensive national training program in aesthetic surgery.