Dear Editor;

Nasal septoplasty is a corrective surgical procedure performed very frequently in otolaryngology and in plastic surgery. Nasal septal surgery is frequently done for the relief of nasal airway obstruction. Although it is usually considered as common and generally performed by incipient surgeons it carries the risk of significant complications (Table 1). Patients’ increased expectations from surgeons are orienting them to a vertical decline in life quality, after the complications of procedure.1

For a proper breathing, the most important anatomic localization is the vestibule and the valve region. Cranial (osseous) and posterior septal deformities like spurs are of less importance for functional benefit of this operation. Functionally, correction of the caudal (cartilaginous) part of the nasal septum is the primary goal for surgeons.2 Complications in surgery can be difficult to avoid, however they can be prevented or reduced by adequate preoperative planning and good operative technique. Preoperative analysis and radiographic studies have a leading role in order to prevent common surgical complications.

In addition to the main complications after septoplasty; there are some unexpected complications. Palatal perforation after nasal septoplasty procedure is extremely rare. A patient with palatal fistula formation after septoplasty procedure is presented in our case.

A 20-year-old otherwise healthy male patient presented to our clinic with a complaint of liquids expelling through his nose 15 days after a nasal septoplasty with submucosal resection. On oral examination, a perforated palate was noticed. There was a 0.50 X 0.40 cm defect in the midline of the posterior hard palate (Figure 1). He did not have a history of any systemic disease or drug abuse. The patient underwent a von Langenbeck palatoplasty with mucoperiosteal grafting of the palatal fistula. The follow-up period was without complication, his symptoms fully resolved, and he had no recurrence of the fistula three months after the operation (Figure 2).

Complications after septoplasty significantly decrease a patient’s functional and aesthetic postoperative results. Postoperative results can be less than optimal in the setting of incomplete resection, extended nasal trauma, or even overcorrection of the septum. As a result every nasal surgeon performing this procedure must be careful and meticulous. With an extensive knowledge and experience, correct surgical technique, and preoperative planning complications can be minimized.3

Palatal defects generally occur as a result of congenital processes, but they can also be acquired. Occasionally, a palatal perforation has been reported secondary to a discreet event such as a cocaine abuse, infection, systemic disease or trauma.4-7 To our knowledge there are very few cases of palatal perforation after septoplasty. Muhammad and Nabil-ur Rahman reported 2 cases of palatal perforation in a series of 200 patients.8 The medical history of these patients was not mentioned. Additionally Ersoy and colleagues9 have presented a case report about a palate perforation after septoplasty in whom they found a submucous cleft during the surgery. This cleft may have facilitated the occurrence of perforation. The presented patient does not have any anatomical variations, systemic disease or

Tablo 1. Complications in septoplasty.1,3

| - Septal cartilage defects and deformities | - Hemorrhage |
| - Infectious problems                        | - Endocranial complications |
| - Alar base deformity                        | - Nerve injuries           |
| - Mucosal bridging                           | - Blindness               |
| - Sagging of nasal dorsum                    | - Inefective results       |

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history of drug abuse that may create a substrate for perforation.

Although septoplasty is widely performed operation with well established techniques complications are inevitable. Palatal perforation, although extremely rare, should be kept in mind especially if the patient complains of liquids expelling through their nose.