

Radiosurgical Excision of Rhinophyma

Letter to the Editor:

I am writing to comment on “Radiosurgical Excision of Rhinophyma.”¹ Somogyvári and colleagues present a nice series concerning radiowave excision of rhinophyma. They present nine cases, cover the disease process well, and use a recognized surgical modality to excise the rhinophyma tissue. The article has merit in discussing 4.0-MHz radiowave surgery as a treatment modality for rhinophyma.

They state that “Alternative methods including electrocauterization and CO₂ [carbon dioxide] laser, via vaporization improve hemostasis but result in scarring and poor cosmesis.” There is no citation for this statement, so I assume it represents the authors’ opinions. Although I am a big proponent of 4.0-MHz radiowave surgery, I also use the CO₂ laser to treat rhinophyma (frequently concomitantly with radiowave excision) and have to disagree that scarring and poor cosmesis are a given with laser rhinophyma excision. As all laser surgeons know, it is not the modality that causes the damage but rather the inability to control the

degree of lateral thermal damage during the procedure. The laser so frequently takes the blame for untoward results, when in reality most problems are from operator error or inexperience. Although excellent for hemostasis, the main problem in using the CO₂ laser to ablate rhinophyma is that it is a slow process (as the authors point out and otherwise previously documented).^{2,3} That being said, if the thermal damage is controlled, the CO₂ laser produces excellent results in debulking rhinophyma and sculpting a smooth surface, and I have been using the laser for this purpose since 1997.

My biggest critique of this article is the authors’ statement that “we describe here a simple, new radiosurgical excision technique.” Radiowave surgery is not a new technique, and its use for rhinophyma has been previously documented,^{2–10} including in this journal. The history of radiowave surgery included the original 3.8-MHz unit, which was used for decades as an alternative to “electrosurgery.” In 1998, a dentist, Dr. Ellman, patented a 4.0-MHz-wavelength radiowave device described in Dr. Somogyvári’s article (unpublished data).



Figure 1. The dedicated rhinophyma electrode has a “cheese wire” function, and the triangular shape allows tissue sculpting without grooves that can be seen with a loop electrode.

Finally, the authors use a loop electrode to remove the strips of involved skin. By nature of the curvature, using a loop can produce grooves or furrows on the surface being smoothed. Ellman International (Oceanside, NY) makes dedicated rhinophyma electrodes, which are triangular, for a “cheese wire” effect and allow a flat surface to be created during excision and in my experience are superior to loop electrodes (Figure 1).

These aforementioned corrections are not intended to be defamatory of this article and are presented for the sake of clinical and academic accuracy.

References

1. Somogyvári K, Battyáni Z, Móricz P, Gerlinger I, et al. Radiosurgical excision of rhinophyma. *Dermatol Surg* 2011;37:684–7.
2. Aferzon M, Millman B. Excision of rhinophyma with high-frequency electrosurgery. *Dermatol Surg* 2002;28:8.
3. Greenbaum SS, Krull EA, Watnick K. Comparison of CO₂ laser and electrosurgery in the treatment of rhinophyma. *J Am Acad Dermatol* 1988;18:363–8.
4. Botero , GES . Giant rhinophyma: a case report. *J Otolaryngol Head Neck Surg* 1996;24:69–71.
5. Bridenstine JB. Use of ultra-high frequency electrosurgery (radiosurgery) for cosmetic surgical procedures. *Dermatol Surg* 1998;24:397–400.
6. Niamtu J. Cosmetic removal of nevi and lesions with 4-MHz radiowave surgery. In: Niamtu J, editor. *Cosmetic facial surgery*. St. Louis: Mosby Elsevier, 2011.
7. Niamtu J. 4.0 MHz Radiowave surgery in cosmetic surgery. *Australasian J Cosmetic Surg* 2005;1:52–9.
8. Niamtu J. 4.0 Mhz Radiowave surgery in cosmetic facial surgery. In: Bell WH, Guerrero CA, editors. *Distraction osteogenesis of the facial skeleton*. Ontario, Canada: BC Decker, 2007.
9. Erisir F, Isildak H, Hacıyev Y. Management of mild to moderate rhinophyma with a radiofrequency. *J Craniofac Surg* 2009;20:455–6.
10. Arıkan OK, Muluk NB, Cırpar O. Treatment of rhinophyma with radiofrequency: a case report. *B-ENT*. 2010;6:209–13.

JOE NIAMTU, III, DMD
*Private Practice,
 Cosmetic Facial Surgery,
 Richmond, Virginia*

A Convenient Technique for Multiple Equal-Depth Intradermal Injections

Letter to the Editor:

Dermatologists use intradermal injection widely to treat various conditions such as alopecia areata, keloids, and hyperhidrosis. Some assistant devices have been invented for multipoint and equal-depth injections, but they are costly and unavailable to some doctors. Lee has reported a technique that helps operators to inject at multiple sites to a relatively equal depth (3 mm) using a double syringe system.¹ It is helpful in our work, but we find that it needs improvement to overcome the instability of the system and to make the injection depth adjustable. Now we introduce a more convenient-way to inject at equal depth.

We take a 1-mL syringe as an example. A desired length, for example 5 mm, from the needle tip to

any point along the needle was marked on the needle cap. The cap was removed from the needle, cut along the marked line, and put back on the needle. In this way, the length of the exposed needle out of the cap was 5 mm (Figure 1). The entire procedure should be conducted under aseptic conditions. To avoid contamination, we



Figure 1. The syringe with newly devised needle cap, which is convenient for multiple intradermal injections.