

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 Somogyvári’s article (unpublished data).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

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