Correction of the Prominent Ear With the Converse Tubing Technique

The main pathologic problem with the prominent ear is the unfurling of the antihelix. My preferred technique for correction of the prominent ear is the tubing approach that was popularized by the late John Converse, MD. After excising an ellipse of skin, I elevate superior and inferior flaps posteriorly and then skeletonize the posterior aspect of the cartilaginous framework. By tilting the prominent ear back toward the skull, I can outline the proposed reconstructed antihelix with ink. I then pass straight Keith needles and use Bonnie blue solution to draw lines on the posterior aspect of the exposed cartilaginous framework. Incisions are made with a number 15 blade through the cartilage along the previously drawn lines. To avoid a sharp anterior margin, the perichondrium on the anterior aspect of the helix is preserved. A third incision is then made along the superior aspect of the concha. I return to the first set of parallel incision lines and create a tube by inserting two or three colorless 4-0 nylon sutures. Observing the anterior aspect of the helix, I cinch the sutures until I obtain a sufficient amount of tubing to create the antihelix and then knot the sutures.

The next part of the procedure addresses the second component of the pathologic problem, which is excess concha. By pushing the ear toward the skull again, I can estimate the amount of concha that must be excised. One must be careful because overresection of concha can lead to the “telephone” deformity. After the appropriate amount of conchal cartilage has been excised, I place a single 4-0 chromic catgut suture to close the gap in the conchal cartilage. Resecting the ellipse of conchal excess and suturing the cartilaginous margins together create a rippling of the anterior auricular skin. I often will dissect the anterior skin off the concha to avoid this temporary rippling. The wound is then irrigated with saline solution, and I close the skin incision with a running 4-0 nylon suture. The only variation that I will make occasionally is to use a conchal mastoid suture—that is, I will place a synthetic suture between the concha and the mastoid fascia to maintain the ear position.

For postoperative dressing, I use little pieces of cotton soaked in mineral oil to fill out the convolutions of the ear and place a larger piece of cotton over the entire ear. Then I place a wraparound dressing. These dressings are kept on the patient’s ear for 96 hours. Although I do not use drains, I am very alert to a complaint of pain at the operative site because this often indicates a hematoma, which should be drained immediately. However, hematomas after otoplasty procedures are unusual.

When you are “fine tuning” the ear toward the end of the procedure, the lobule is often overprotruding, and I often find that I have to dissect out the tail of the helix through the posterior incision. I have even resected the tail of the helix to allow the lobule to lie in the same plane as the reconstructed ear. I am opposed to anterior incisions in the ear because I believe the ear is prone to hypertrophic scarring.

My tubing technique also permits flexibility. Prominent ears usually are not asymmetrical, but when they are, my technique allows me to do more tubing on one side than on the other. It also allows me to resect varying degrees of conchal excess. I do not believe that any surgical technique is good unless it allows the surgeon to be somewhat flexible.

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