VII. Secondary Surgery

39. *The Importance of Winning*

BY definition this *secondary* section is devoted to the losers who, for one reason or another, *temporarily* have to be placed in the minus column. To avoid having such a calamity happen to a patient in the first place, and to correct it when it does in the second, calls for us to take a *hard* line.

As the renowned Notre Dame football team suffered loss after loss over several years, a frantic search was begun for another winning coach like the legendary Knute Rockne. The University of Notre Dame, the U.S.A. mecca for Catholic students, after both coach and soul searching, decided in a businesslike manner to sign aggressive Ara Parsegian, an unlikely French-Armenian Presbyterian, as head coach. They announced to him with very little ceremony,

We are behind you 100 percent—*win* or *tie!*

And Parsegian did succeed, placing Notre Dame back in the winning column and reviving the victory spirit at South Bend. Then, on the way to an undefeated season, the team suffered an upset defeat by Purdue University. Coach Parsegian, overworked and in semi-collapse, admitted himself to the hospital for a "recovery period," fully aware that the University Athletic Advisory Committee was meeting simultaneously to decide his fate. He waited anxiously. Finally, a telegram from the committee arrived:

We wish you a speedy recovery by a vote of 4 to 3.

Parsegian, after a number of "secondary corrections," finally

achieved his desired result. Notre Dame University defeated the University of Alabama in the 1973 Sugar Bowl. His team was in the number one spot in the nation.

Cleft surgery is far more than a game. The stakes are higher and winning is vital, as a loss is a disaster. A most disturbing fact persists: Try as hard as we may, we still cannot quite win them all. But we have to keep trying!

It is the hope of all cleft surgeons that the initial surgery will be so effective that no further correction will be necessary. As noted by Muir and Bodenham of Great Britain for Gibson's 1966 *Modern Trends in Plastic Surgery,*

> There is evidence, however, that primary cases treated by the more advanced techniques of today—for example, rotation advancement . . . will need less major surgery than previous generation cases.

Certainly as the primary surgery improves, the secondary work is reduced until it amounts to no more than minor revisions.

Many pages have been devoted to why and how to plan the primary procedures and if these are understood and executed with skill befitting a plastic surgeon, that should be the end of it. Unfortunately, there are still patients who have been operated on without benefit of modern developments. Either their surgery was executed too many years ago or it was done more recently by untrained surgeons.

Secondary surgical correction of cleft deformities is a whole new ball game, but the rules that govern the primary operation also hold secondarily: *Know the normal, find it and place it in normal position, throw away nothing until it is proved useless, borrow from an area of excess to correct an area of need only when it can be afforded, do not get shackled in routine but look at each case individually* and when surgery, growth or lack of growth has been responsible for loss of tissue, then *replace lost tissue with similar tissue in kind.*

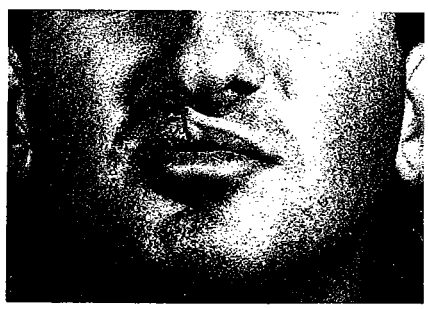
It is vital that the *first failure not throw the surgeon into panic, so that his second effort is neither irrational nor repetitious of the previous error.* If the secondary surgeon could be guided by such simple, sound dicta as

Never make the same mistake twice.
Two wrongs do not make a right.
When in doubt, don't!

the tertiary surgeon would have little or nothing to do.

THE ORDER OF LINEUP

Secondary corrections must be subdivided into so many categories that it is difficult to know what to put where! There are corrections dealing with the lip and those dealing with the nose and some dealing of necessity with both at the same time. What is indicated for a unilateral deformity is not always ideal or must be modified for a bilateral problem. There are general methods that can be adapted specifically to the common result seen after certain standard primary lip operations. All this overlapping makes some repetition unavoidable.



Of course, when the fundamental principles of the surgery were wrong, the faults will be glaring. But even with sound principles there is always the possibility of human error of hand and eye, and all scars just do not heal equally well. Areas of secondary error in the lip vary with the primary methods but are most common in the scarring, the muscle approximation, the contour, the landmark preservation and alignment and free border symmetry.