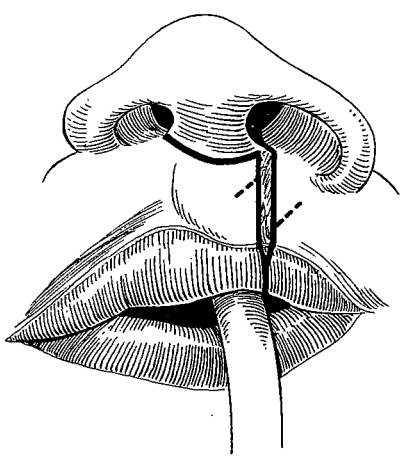
52. *Combined Nasal and Labial Unilateral Cleft Corrections*

THE simultaneous correction of secondary labial and nasal deformities had been done by surgeons for many years. Gillies and Barron taught me this combined approach in 1948. George Pap of Frenchay Hospital, Bristol, England, advocated the combination of rhinoplasty, septal correction and lip revision in 1955.

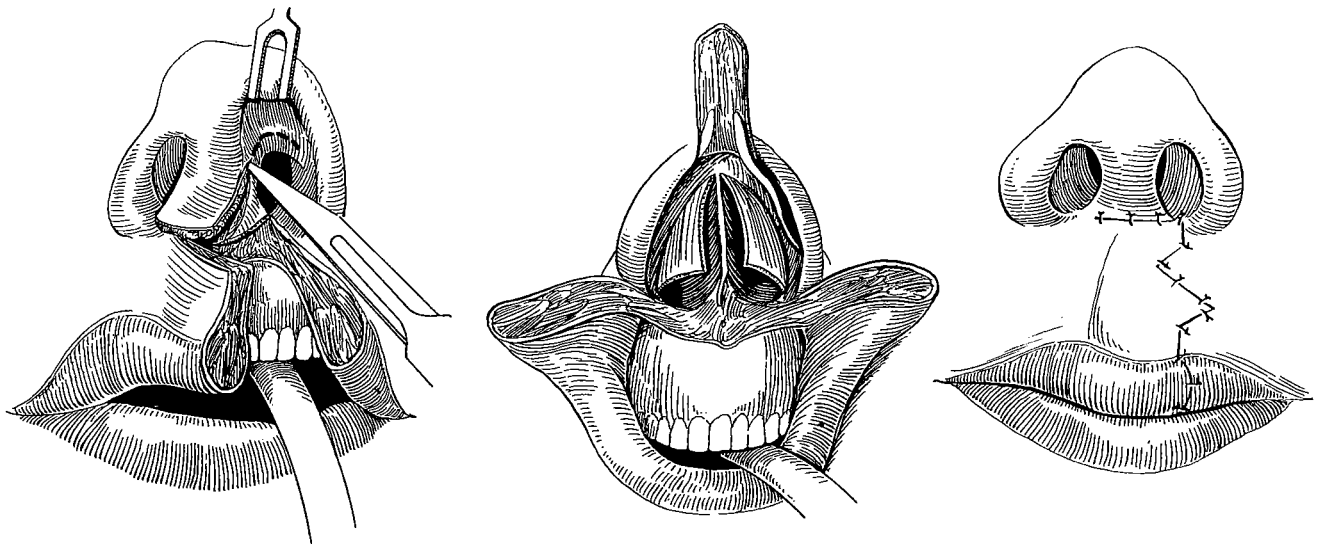
ANGLO-AMERICAN

Sir Archibald McIndoe of London and East Grinstead and Tom Rees of New York, two of the smoothest operators ever in plastic surgery, combined forces in 1959 on the synchronization of lip and nose correction of secondary cleft deformities. They outlined the steps:

1. Complete "take-down" of the scarred lip with excision of all scar tissue. . . .
2. The preparation of flaps for a satisfactory lip repair. . . .
3. A nasal reduction with shortening of the nose if necessary, removal of bony and cartilaginous hump and infracture of the nasal bones. . . .

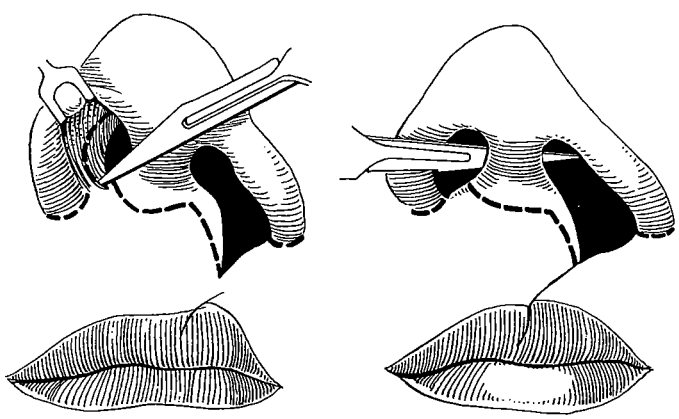


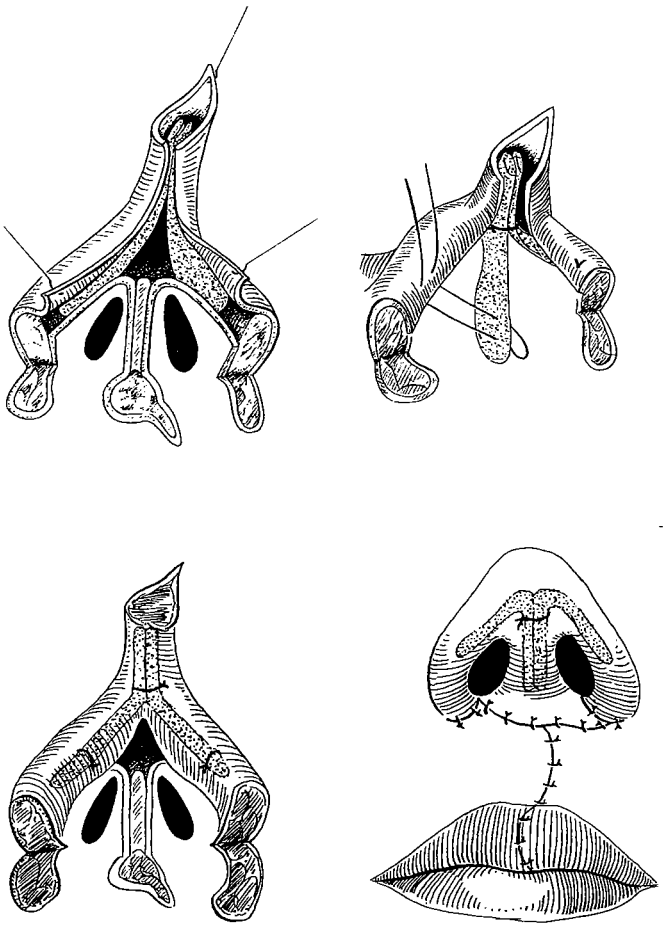
4. Remodeling of the nasal tip by total bilateral mobilization and symmetrical realignment of the distorted alar cartilages.
5. Submucous resection of the distorted septum, if this is necessary, to centralize the nose or clear the airways.
6. Dental extraction of hopelessly involved teeth.



BRAZILIAN

Pitanguy of Rio, a bold surgeon flanked by his capable adjutants, executes his daily operative schedule like a Napoleonic campaign and probably does more cases a year than any other plastic surgeon. It would be logical for him to combine the labial and nasal correction in a secondary operation. In 1963 he described his combined approach with the lip skin incisions utilizing the rotation-advancement principle, including even the use of flap c for the nostril sill construction. Then, with the aid of alar base incisions and a membranous septal incision to lift the





columella along with a cleft-side paramarginal incision, an "open ceiling" exposure facilitated the freeing, shifting and suturing of the alar cartilages together for an improved nasal tip contour.

SWISS

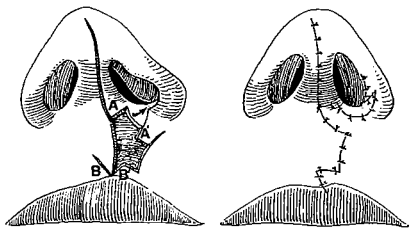
A colorful, diagramatic nasal textbook, *Plastiche Operationen am Kopf und Hals,* published in 1964, was co-authored by H. J. Denecke, an otolaryngologist in Heidelberg, and Rodolphe Meyer, a plastic surgeon in Lausanne. As I wrote in reviewing the book for *Surgery, Gynecology and Obstetrics:*

> From the natural rivalry of these two specialties it might be conjectured that this successful union was due to, rather than in spite of, the distance between Heidelberg and Lausanne.

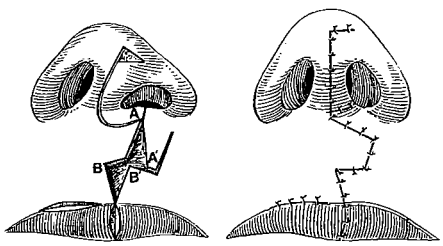
Rodolphe Meyer

In Meyer's section there appear some wild but intriguing combinations of labial and nasal secondary corrections. As agile

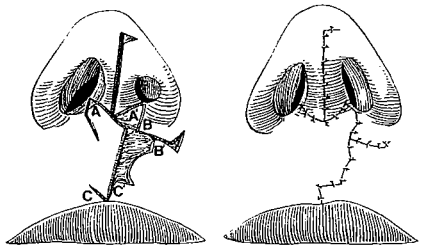
as Rudy may be, he could never cut a path like these on one of his Alpine ski slopes, but in cleft lip and nose secondary work, problems faced are stranger than fiction, and variation in the corrective design must face up to each idiosyncrasy. Of course, the results will be no better than the principles of the methods used.



Gillies-Trauner-LeMesurier



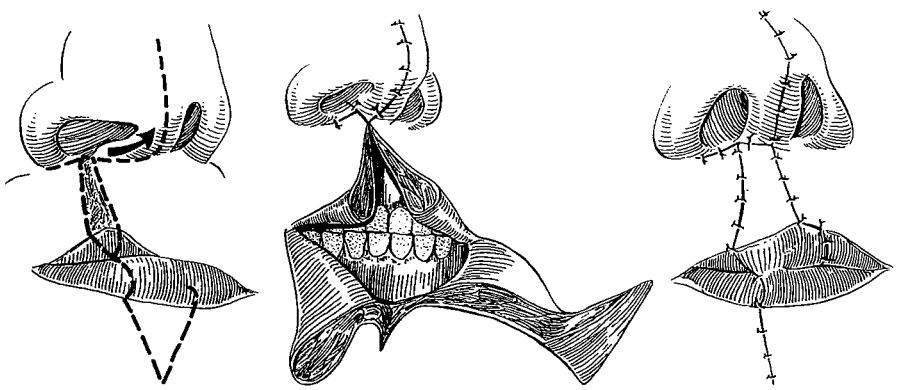
Sheehan-Trauner
Trusler-Glans



LeMesurier-Meyer

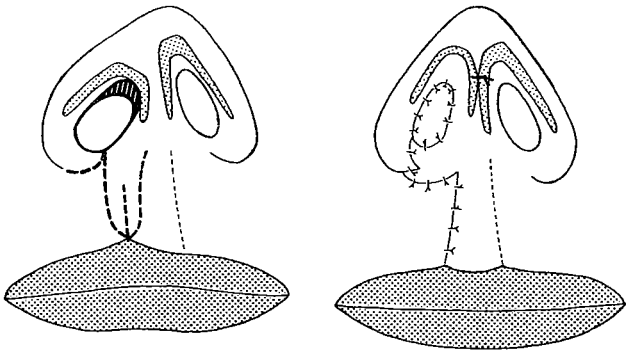
FRENCH

Paul Tessier of Paris, with Delbet, Pastoriza and Aiaich, in 1969 advocated a synchronized, simplified Schjelderup unilateral nasal correction along with a lip revision and small Z-plasty. If the lip was tight from side to side, then he augmented the lip with a unilateral Abbe flap inserted into the scar excision at the same time.



SWISS

In 1971 Neuner of Berne described a combined correction of the lip and nose along the forked flap principle. He improved the lip scar by raising a unilateral forked flap and split its tail. The membranous septal incision, which was used to facilitate



advancement of the fork, was continued up and all the way around the vestibule, ending behind the alar base and turning the latter into a flap. Then, with a rotary motion, the cleft-side alar cartilage was elevated and sutured to the normal cartilage as the fork advanced out of the lip into the columella and nasal floor with its split tail encompassing the point of the alar base flap.

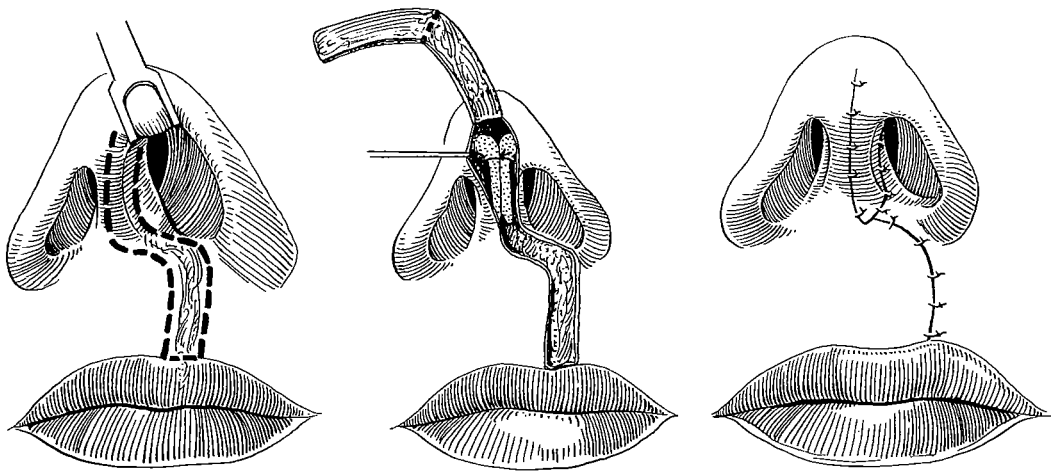
U. S. ARMY ISSUE

Norman Hugo

Another combination of secondary nasal and labial correction was described in 1971 by Norman Hugo, then of Michael Reese Hospital, now at Northwestern University, and Colonel Wilfred Tumbusch of Brooke General Hospital. First they placed onlay rib grafts under the alar base to the maxillary defect of the cleft. Then the old lip scar was picked up as a unilateral prong of a forked flap which was incised first horizontally and then anteriorly up the middle of the columella and posteriorly in the membranous septum. This developed a long flap which could be advanced into the columella toward the nasal tip, with any excess of the distal scarred flap being excised. This exposure allowed dissection and suturing of the cleft alar cartilage to the normal. The alar base was advanced medially. Hugo and Tumbusch stated:

> Closure of the defect symmetrizes the nostril floors and the incision heals to resemble the cicatrix of a Millard cleft lip repair.

They admit less-good results with secondary cases in which excessive scarring has been created in the columella base area and in the vestibular lining of the lateral alar region.



At least their nasal scarring is limited to the mid-columella and does not extend over the nasal tip.

BACK IN TEXAS

There are obvious advantages to a simultaneous nasal and labial correction, since one helps the other. Gillies enjoyed performing these procedures, and in my early days, I must admit, I was rather pleased with such extensive taking apart and reassembling. It does not always work out for the best. Once, in 1951, as a resident at Jefferson Davis Hospital, Houston, due to limited main operating room time, I had finagled the use of a small minor surgery outpatient room well out of the way of hospital traffic. Only a snooping nurse ever wandered by, and a lot of work was being done. One day I was operating on an adult male daredevil clown from the Shamrock Hotel water show, who had a unilateral cleft lip with the typical secondary nasal deformity. His lip had been opened wide and his columella elevated, with excellent exposure for nasal correction. The osteotomies were being done, and it was a little more bloody than usual, but I was alone and working along quite happily.

Michael DeBakey

"Doctor, *what* are you doing?"

came rather sternly from a faintly familar voice. I looked up to see his majesty the chief, Dr. Michael DeBakey. "Oh, good afternoon, sir," I said, and then trying to get him involved, "You see, once I get the nose back together, these lip flaps will ap-

proximate so. . . ." There was not a flicker of expression, and when I looked up again, he was gone. Word came down the next day through Baron Hardy that only minor surgery was to be done in minor surgery. The clown, however, healed up so well he gave up his clowning.

There are other reasons for reconsidering too much simultaneous surgery. At least for me, concentration on one main aspect well enough to get it really right is facilitated by having a minimum of distractors. Unless one operation is benefited by the simultaneous execution of another operation, I prefer to let the first one heal and return another time for the meticulous correction of a separate problem. The all-in-one shot often falls short of the mark, and its justification depends on the specific combination of deformities and the personality and aspirations of the operator.