16. *Nasal Demands*

A grating refrain constantly being chanted during final evaluation of every bilateral method that does not take the prolabium primarily and place it bodily into the columella is:

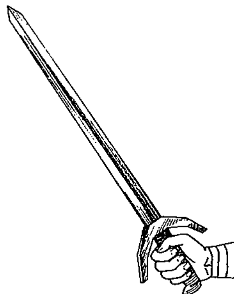
OK, a satisfactory upper lip!
But what about the *short columella*
And the flat *nasal tip!*

Several surgeons in the nineteenth century willingly placed the total prolabium into the columella position, and a few are still doing it in the twentieth century. Yet, for the majority, it was all they could do to get the lip together even with the prolabium as a central assistant. Several orthopedic-oriented surgeons, like Denis Browne and LeMesurier, while making important contributions to the lip surgery, admitted quite frankly that the nose was out of their realm and either accepted the nasal discrepancy or abdicated to the plastic surgeon. Thus when the columella needs are ignored from the moment of the first surgery, the nasal tip goes down in defeat in its struggle with the lip for the prolabium. Obviously, the answer is *compromise.*

SOLOMON'S SUGGESTION

As it says in the Old Testament, I Kings 3:16, two harlots came and stood before the king. Each had had a child. One had inadvertently smothered hers during sleep but, upon discovering her dead child, exchanged it for the live one in the night. The next morning at breast feeding, the other woman realized that

her child had been replaced by the dead one. Each woman insisted the living child was hers. Finally their argument was brought before King Solomon.



24 And the king said, Bring me a sword. And they brought a sword before the king.
25 And the king said, Divide the living child in two, and give half to the one, and half to the other.
26 Then spake the woman whose the living child was unto the king, for her bowels yearned upon her son, and she said, O my lord, give her the living child, and in no wise slay it. But the other said, Let it be neither mine nor thine, but divide it.
27 Then the king answered and said, Give her the living child, and in no wise slay it: she is the mother thereof.
28 And all Israel heard of the judgment which the king had judged; and they feared the king: for they saw that the wisdom of God was in him, to do judgment.

The prolabium dangles like the cherished living babe, claimed vigorously by the nose and just as vehemently coveted by the lip. As we have seen, through the centuries, some surgeons with compassion have cut it free with their scalpels to go into the nose while others with equal compassion have pared it to go into the lip. I believe, cruelly calculating as it may seem, that King Solomon's original suggestion to divide "the child" is actually the *wisest!* Compassion has no place here for in actual fact, if wisely divided, the prolabium can serve the nose and serve the lip with benefit to both and without sacrifice to either.

PROLABIAL SHARING

Surgeons have designed various ways for sharing the prolabium between the lip and the nose. Some are better than others. The most common is primary insertion of the prolabium into the lip and then, as a *delayed primary* procedure, taking part of it for the columella in order to release the depressed nasal tip.

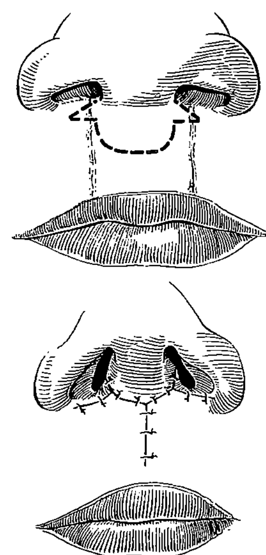
STEALING FROM THE CENTER

In 1833 Gensoul used a vertical V-Y advancement out of the upper lip into the columella to increase the columella length.

From present-day experience we know that this could give only a moderate but inadequate release of a truly depressed nasal tip, but it was a vital, if short, step in the right direction.

This type of procedure tended to tighten the lip from side to side but, in addition, caused vertical lengthening which was particularly unattractive. Exploiting the same principle by adding transverse lateral wings to the vertical flap, Blair, with his trefoil plan, lengthened the columella but shortened the vertical length of the lip at the same time.

Then, in 1941, more than a hundred years after Gensoul proposed this principle, Brown and McDowell embellished it by reducing the trefoil to a fleur-de-lis. Six years later, Brown, McDowell and Byar's comments were of interest:



> These children who are born with a total double cleft and almost no columella will frequently require secondary elongation of the latter so that this may be considered standard in this type of patient. Elongation is achieved for the columella by advancing a flap from the upper lip into it. The small cut in the septum out near the tip is usually necessary to get the tip forward and is filled in with small darts on the sides of the flap which come from the nostril floors. The defect in the lip is closed without suturing it to the new columella.

Of even greater interest was the comment:

> Further elevation of the nose may be obtained when desirable, by an "L-shaped" cartilage transplant.

A schedule was suggested, by a case shown, of lip closure during the first days of life, columella elongation at about three and a half years of age and preserved L-shaped cartilage transplant inserted at age six. This confirms what the fleur-de-lis design intimates: Often there is not enough tissue supplied to lengthen the columella sufficiently to raise the nasal tip to normal. Then too, as with most columella lengthening procedures, additional support with a cartilage graft is often indicated.

The greatest disadvantage of all these columella lengthening procedures from the center of the lip was that a *third vertical scar* was added to the two scars already present.