

21. *Joining the Muscles*

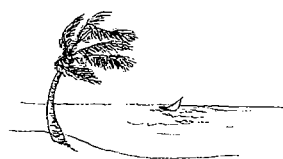
FLYING SOUTH

THE paucity of bilateral lip clefts in the Miami area in the latter part of the 50's caused me to look elsewhere for cases. Jamaican Kenneth A. McNeill, F.R.C.S., had qualified in medicine at St. Bartholomew's Hospital, London, and served with Joseph Sankey at the Facio-Maxillary and Plastic Surgery Unit, Barnsley Hall Hospital, Bromsgrove, England, during World War II. After hostilities ended, he had returned to Kingston, Jamaica, and started a voluntary plastic surgery unit. During a visit to Miami he invited me to come to work with him in his Caribbean paradise, setting the bait with a promise of plenty of bilateral cleft cases. At the mere mention of bilateral clefts I began tossing instruments and sutures into a bag and almost beat McNeill back to his island in the sun. Thus, a happy cooperation was begun in 1959 which has lasted over all these years. McNeill is now Minister of Health and is planning a plastic surgery center in Montego Bay with a special section for cleft lip and palate work.

At first I tried the delayed primary forked flap again. The diminutive prolabium of pea size was incorporated in the lip and the lateral vermilion flaps were used to overlap the inferior prolabium vermilion. Then, during my next visit to Kingston several months later, the delayed forked flap was advanced out of the lip into the columella with release of the nasal tip.



Kenneth McNeill



note the stretch of the prolabium!



1 year



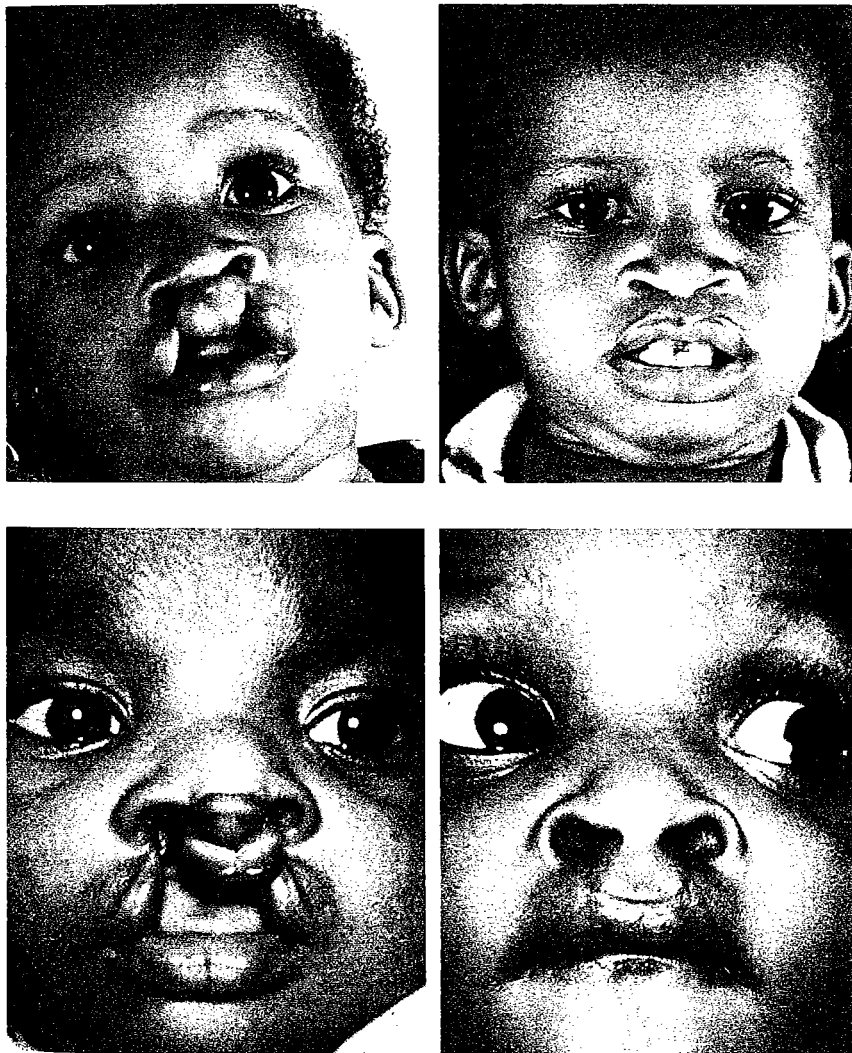
4 years

Attaching the lateral muscle elements to the sides of the pea-sized prolabium stretched the prolabium so much that in a few months it could quite easily give up a forked flap to the columella and still retain a normal-sized philtrum. Thus, the compromise had been successful as far as apportioning tissues between the lip and the nose was concerned, but the lack of muscle continuity across the cleft left unnatural lateral bulges on either side of an unanimated muscleless prolabium.

Another prolabium was *stuck* between the muscular lateral lip elements in preparation for a secondary forked flap. This was an example of the just described "conservative" approach—with no primary lip muscle union and a delay of the forked flap for years—that I was using in Miami at the time.



Then it was decided that, to improve the lip appearance and action, muscle continuity across the cleft was necessary. Therefore, on a number of bilateral clefts in Jamaica, I used the Meyer-Schultz-Browne-Glover mucosa and muscle closure behind the prolabium and noted definite improvement in lip function. Because of the lack of stretch in the prolabium, the forked flap had to be postponed five years or more. Under this regimen, the lips in the bilateral clefts in the Caribbean Negro were developing so well that the shortness of the columella, although detracting from the ideal result, still did not quite justify an early secondary forked flap. The lip scars following the primary operation in the infant were so good that enthusiasm for additional surgery of the lip to aid the nose was discouraged.





Furthermore, the Jamaican parents were satisfied and only under duress would they return to the clinic with the child. It was disturbing to have results accepted when they fell short of the possible nasal corrections, and in the Caucasian the discrepancy, of course, was worse.

Then a case using this same approach ended up with a nasal tip so flat that this aspect could no longer be ignored.



Here was the spark that set off the primary forked flap.