

55. *Miscellaneous Revisions, Mostly Nasal*

THERE are certain cases in which several procedures have made subtle improvement in the total effect. The deformity is not always glaring, the solution not necessarily exciting, but the little change makes everyday existence a little easier as it helps the patient blend into his surroundings without being constantly picked out as odd or just different.

A ROUND TIP AND A REENTRANT ANGLE

This bilateral cleft of the lip and palate had been operated on in three excellent medical centers. A wide Abbe flap had already been transposed and a Silastic implant to the nasal tip had been and gone! The patient was a pleasant 18-year-old girl with a suggestion of a parrot's beak of the nose and inequality of scarring of the lips.



18 years

R.R. Through the Potter-type marginal "flying bird" incision, the columella skin was elevated, presenting exposure for bridge lowering and alar cartilage reduction. Subcutaneous tissue and a cartilage strut in the columella were turned up for nasal tip support and columella reduction. A V-Y advancement lengthened the upper lip slightly.

The roundness of the columella in profile was exaggerated by the reentrant nasolabial angle. Six months later, despite previous incisions, a midline vertical ellipse of excess columella skin, based on a subcutaneous pedicle directed inferiorly, was incised and advanced down into a releasing incision across the retracted nasolabial angle where the columella joined the lip.



Final improvements included minor scar excisions and sandpaper abrasion. The abrasion was aided by a common trick of



21 years

painting methylene blue over the irregularities to mark the pits and to ensure complete de-epithelialization.

After the last surgery the patient faced her greatest test when she started teaching. She wrote a happy note that the students had accepted her—but she says it best:

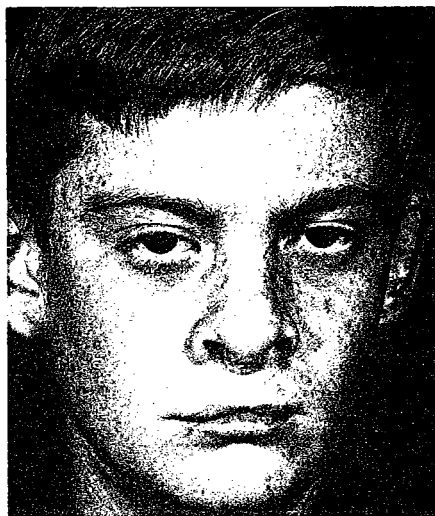
I am so excited and pleased with my surgery. The redness and roughness were gone within a very few days. I have gotten so many compliments on your work. I started my teaching field experience and I passed the biggest test of all. Usually the first question I am asked by the children is what happened to your face. They have been all over me and all they have asked for are my braces. That really makes me feel good.



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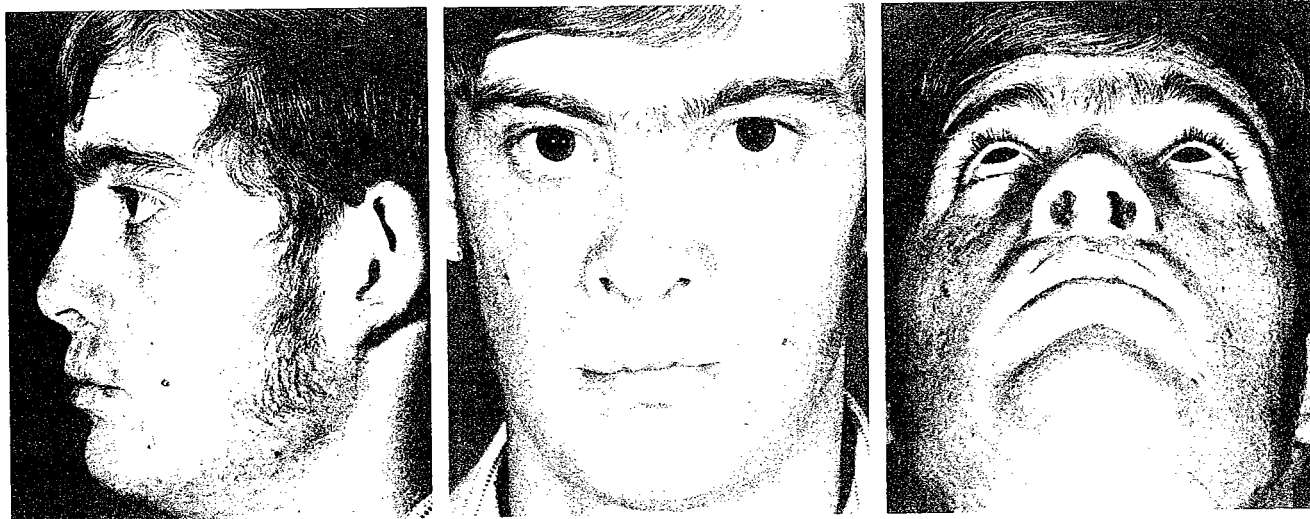
AN OVERTREATED COLUMELLA

Here the columella of a bilateral cleft lip and palate had been lengthened, probably then became retracted and was overtreated with a Silastic implant. At 14 years, the nasal tip was flat, the alae were flared, the nostrils were without sills, the columella was thick and prominent and the central vermilion of the lip showed a whistling deformity.



14 years

R.R. The alar bases were advanced across the nasal floor to reduce the flare and create nostril sills. Midline longitudinal elliptical excision of the columella and removal of the Silastic implant reduced the mid-column. Reduction of the alar cartilages and the hump and bilateral osteotomies and alar cartilage folded as free grafts to the membranous septum improved the nose. A V-Y advancement posterior mucosa created a tubercle in the whistling deformity of the lip.



17 years

THE SHARP-ANGLED NOSTRIL AND COLUMELLA RETRACTION

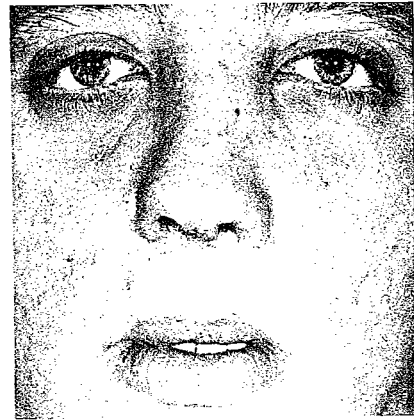
This bilateral cleft lip and palate patient, after an untold number of surgical procedures, presented retroposition of the maxillae, most noticeable in the alar base areas, a columella with retraction, a peculiar asymmetry of the nostrils, a protuberant lower lip and a receding chin.



Cancellous iliac bone grafts were placed between the maxillae and the premaxilla and under the alar bases. A Silastic sponge was inserted through a labial sulcus incision to improve the chin projection, and a wedge resection of the lower lip reduced its protuberance. Then a reduction rhinoplasty was carried out, and cartilage from the hump and septal submucous resection was inserted into the columella through a midline vertical skin-splitting incision. Finally, a left alar marginal "excision" was retained as a flap based superiorly and medially and transposed back into the vestibule at the top of the arch to round out the *sharpness of the ala-columella angle* and to symmetrize the nostrils at the same time.

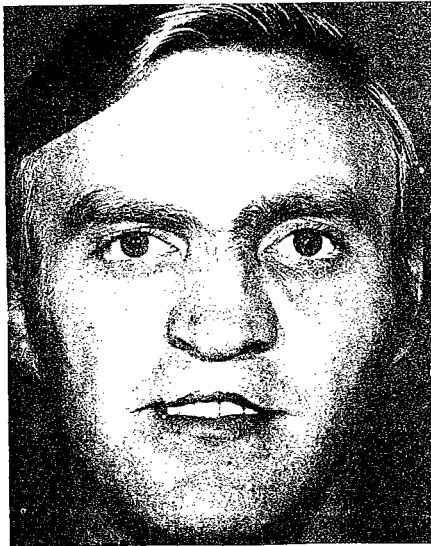
R.R., S.M.R.
S.C.S.2

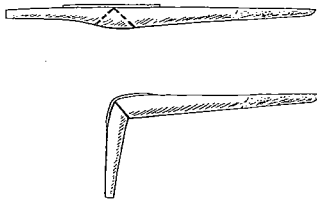
A.R.3



FLAT NOSE

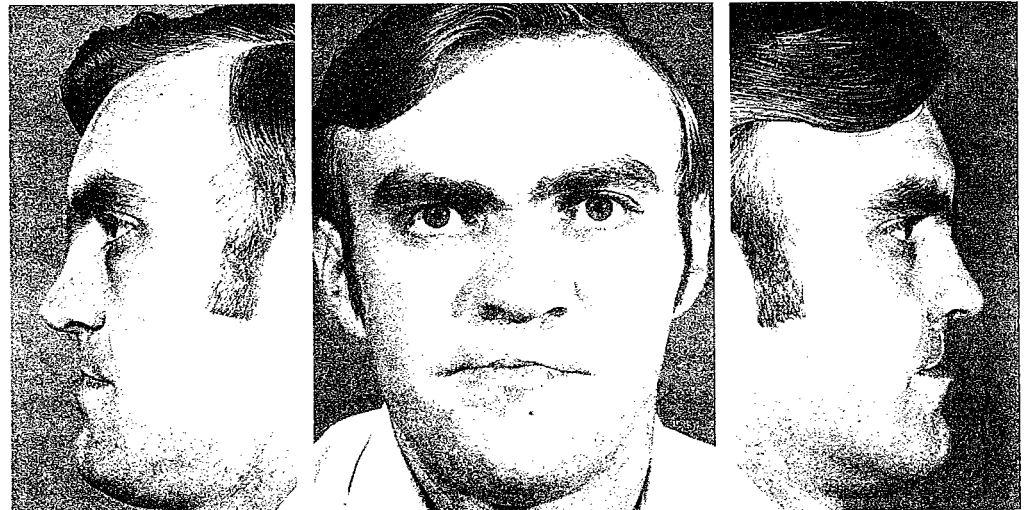
This 26-year-old man had a bilateral cleft lip closed in infancy with the prolabium in the center of the lip. The columella



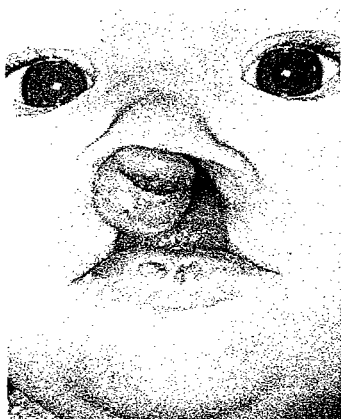


seemed long enough, but the nose had also suffered several fractures. Whether the condition was congenital, traumatic or both, the nose and maxillae were flat, lacking normal projection.

Through a columella-splitting incision, a costal osteochondral hinge graft was inserted to raise the bridge and correct the columella retraction. Bilateral osteotomies narrowed the nasal bones. Then, through upper labial sulcus incisions, the periosteum was elevated from the maxillae, particularly under the alar bases, and cancellous bone chips were packed over the maxillae. The alar base was denuded of epithelium and advanced to balance the opposite alar base, which had been reduced by a wedge resection.



The patient would now benefit by an Abbe flap and eventually may accept it.



GRIDIRON LIP SCARRING

A 17-year-old girl, born with a complete bilateral cleft of the lip and palate and a pair of mucous pits of the lower lip, was treated at various U.S. naval hospitals and provides a case against the armed services' shifting of patients from doctor to doctor. Evidently the lateral segments were attached to the prolabium primarily, resulting in the usual stretching and flattening of the prolabium, which bulged against the projecting premaxilla.

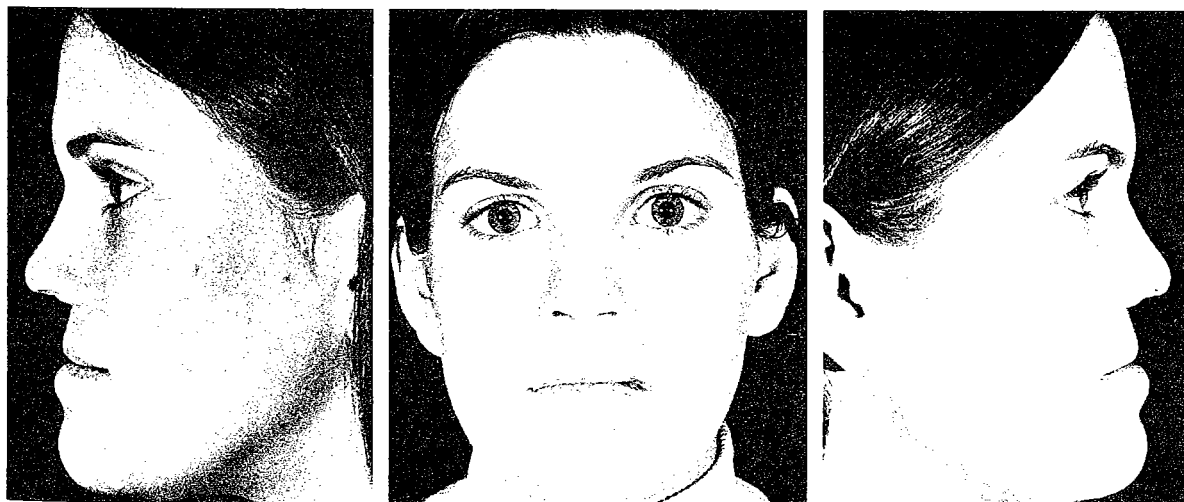
At one stage, as shown, circumalar cheek incisions were used, probably in a frantic attempt to mobilize the cheeks to aid the lip. A Gensoul-type flap was shifted into the columella, with reasonable nasal tip release, but the price of this maneuver totaled three vertical scars in the upper lip, which also tightened the lip to even more noticeable flatness.



This situation stimulated another surgeon at another naval hospital to call upon an Abbe flap. It had to be taken from an unsatisfactory lower lip that had previously had a pair of mucous pits excised and reexcised. The cost of this action was the addition of two more scars or a total of four vertical upper lip scars, not unlike a gridiron.

To have a plastic surgeon in every port is almost as difficult for the surgeon as the patient.

When first seen as a secondary problem, the patient was 17 years old with a retracted columella, cheek scars, a flat lip with four vertical scars and one scar of the lower lip. Her maxillary and



17 years

mandibular relationship and occlusion were considered within normal limits by orthodontist Berkowitz. Even more impressive was her cheerful, optimistic and appreciative personality.

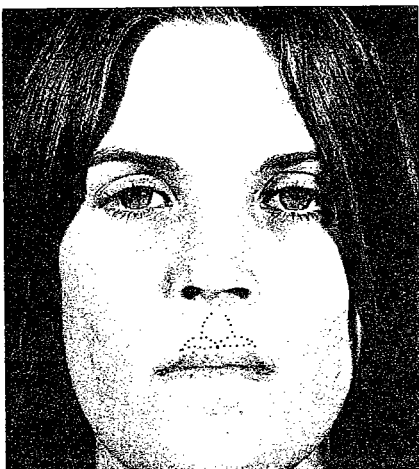
S.M.R.
S.C.S.2

Bilateral upper labial sulcus incisions with back-cuts allowed freeing of the labial mucosa and its medial advancement. After the orbicularis oris muscles had been sutured together behind the prolabium, the posterior mucosal flaps were rotated and sutured, giving more fullness to the free border. A submucous resection of septal cartilage supplied two struts, which were introduced into the columella to relieve its retraction and give improved definition to the nasal tip.



18 years

The flatness of the lip and the absence of the cupid's bow inspired the use of my modification of the cupid's bow operation. As the lip was not long vertically, it was necessary to keep this a



19 years

“mini” procedure, further bolstered by the grafting of subcutaneous tissue in the mid-tubercle area. Sanding abrasion of alar base, cheek and all four vertical lip scars gave some improvement. The final result has been touched up with routine makeup.

ASYMMETRIES, ANGLES AND BORDER SCARRING

This bilateral cleft patient was born one of twin girls. Over her first 10 years she had 14 operations, which included a forked flap, a Cupid’s bow procedure and bilateral commissurotomy. At 11 years of age she revealed a nasolabial angle snubbed abnormally wide open, asymmetrical nostrils, scarring of the normal mucocutaneous junction ridges and destruction of the natural commissure angles with widespread irreversible scarring. The upper lip was slightly tight in relation to the lower, but its vertical height was within normal proportions. This result represents inartistic use of accepted standard procedures, which while improving the original deformity also creates some extremely perplexing secondary problems.

*half-right
secondaries
compound
the error!*

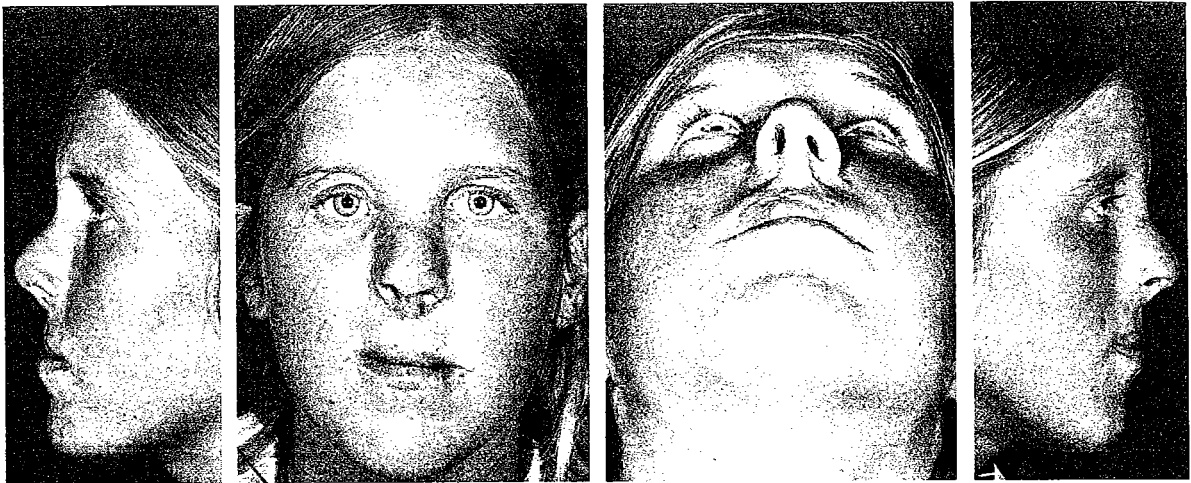


11 years

I first saw the patient at 11 years and stalled secondary surgery for six years, during which time more thought and worry were spent on her than on any other cleft case in my experience. In the first place, the problem was extremely difficult because a Cupid’s bow operation had scarred the natural mucocutaneous ridge and a forked flap had lengthened the columella with asymmetry and an unnatural nasolabial angle. As the little patient and I shared

*when in
doubt,
don't.*

the same beach club, there was the constant opportunity for observation benefited by comparison with her attractive mother and non-cleft twin. Time did not achieve miracles.



17 years

Finally, at 17 years, a cleft lip rhinoplasty included alar cartilage reduction, bridge lowering, and septal shortening at the A.B.5 nasal spine. A V-Y lateral advancement of the alar bases opened the nostrils and lowered the strangely elevated nostril sills. Upper labial sulcus incisions with bilateral mucosal advancement gave the lip more freedom and body.



18 years

One year later, further alar cartilage reduction and more radical bridge straightening followed by bilateral osteotomy improved the general shape. A submucous resection improved the airway and provided septal cartilage struts which were used to improve

the columella. One strut was inserted in the upper columella to give nasal tip thrust; a second strut was used to increase the columella convexity in profile.

Free border vermilion trimming and a soft tissue free graft to the tubercle improved the lip shape.



21 years

She is in college and having a happy time.

LOOKING BACKWARD AND FORWARD, BILATERALLY

As we glance back, it is almost painful to recall how the evolution of a sound, staged solution to the *primary* bilateral cleft lip deformity has demanded such a prolonged, rugged climb interrupted by side-tracks, dead-ends, drop-offs, detours, lay-bys and back-tracks. True to the motto of *striving for the beautiful normal*, guided by basic principles and influenced by critical evaluation of results, I am continually trying to formulate and put into action a design that can both *promise* and *produce* happy results with minimal secondary deformities requiring fewer corrections and offering greater potential for perfection.

Yet possibly almost as encouraging is the hope that can be offered to those cases in which many basic principles already have been severely violated, producing results that are truly frightening. If the *same old principles* are conjured up again, they can be used to correct seemingly irretrievable secondary deformities and actually achieve end results that are near normal and sometimes even attractive.

Semper investigans, nunquam perficiens.

Always seeking, never quite achieving perfection.