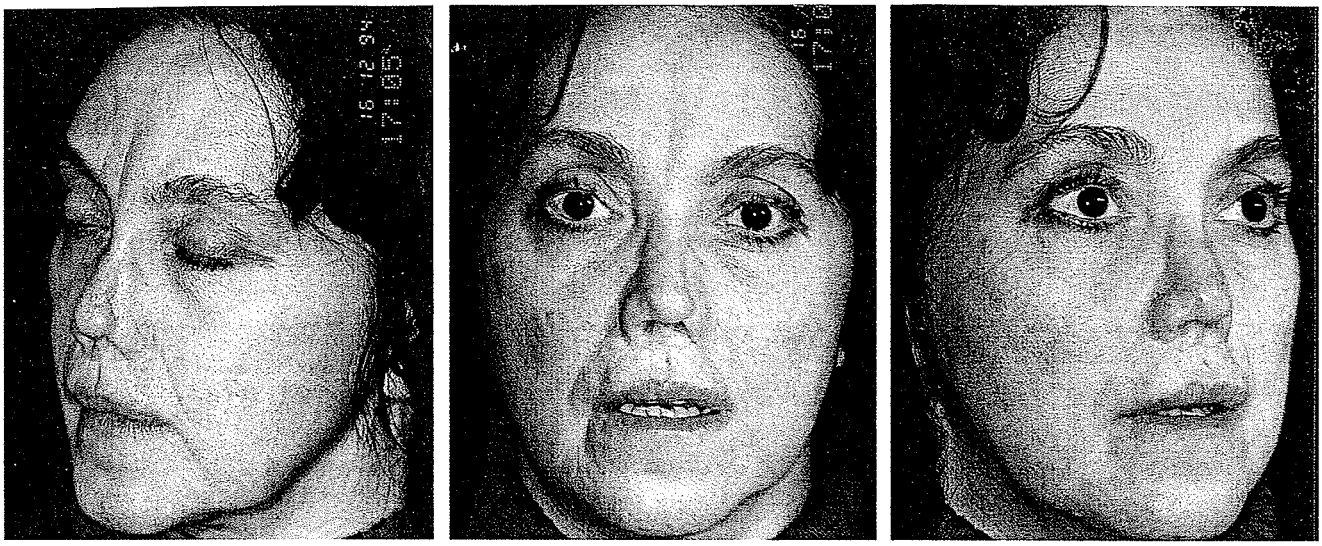
An Epilogue

Over the past 30 years a number of letters have arrived with enclosed photographs of patients with unusual problems accompanied by requests for instructions what to do. Time and time again I have diagrammed the logical plan but seldom ever hear whether the design was used and, if so, how the case turned out. Of course it is difficult to go entirely by photographs. Seeing the patient directly and being able to palpate as well as observe from every angle, brings a helpful dimension to the diagnosis. It is important also to know to whom you are trying to transfer complicated surgical directions. It helps to be familiar with their training and extent of expertise. When previous residents or fellows write for suggestions, it is a pleasure to comply.

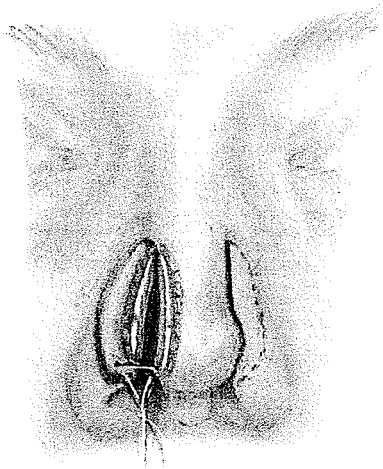
This is what happened recently when G. F. Maillard, a fellow at the University of Miami School of Medicine in 1976 who is now a savvy, world renowned plastic surgeon in Lausanne, wrote a short note. He forwarded three photographs of a patient who had had numerous operative procedures on her nose.



Let me quote Maillard. "A real cripple! the nose is a block of scars! She was operated for an aesthetic rhinoplasty by about ten different plastic surgeons in Europe (nasolabial flaps, columella reconstruction with helix composite grafts and parasagittal open rhinoplasty were the last procedures). What would you do in this case? Leave it or consider a complete reconstruction?"

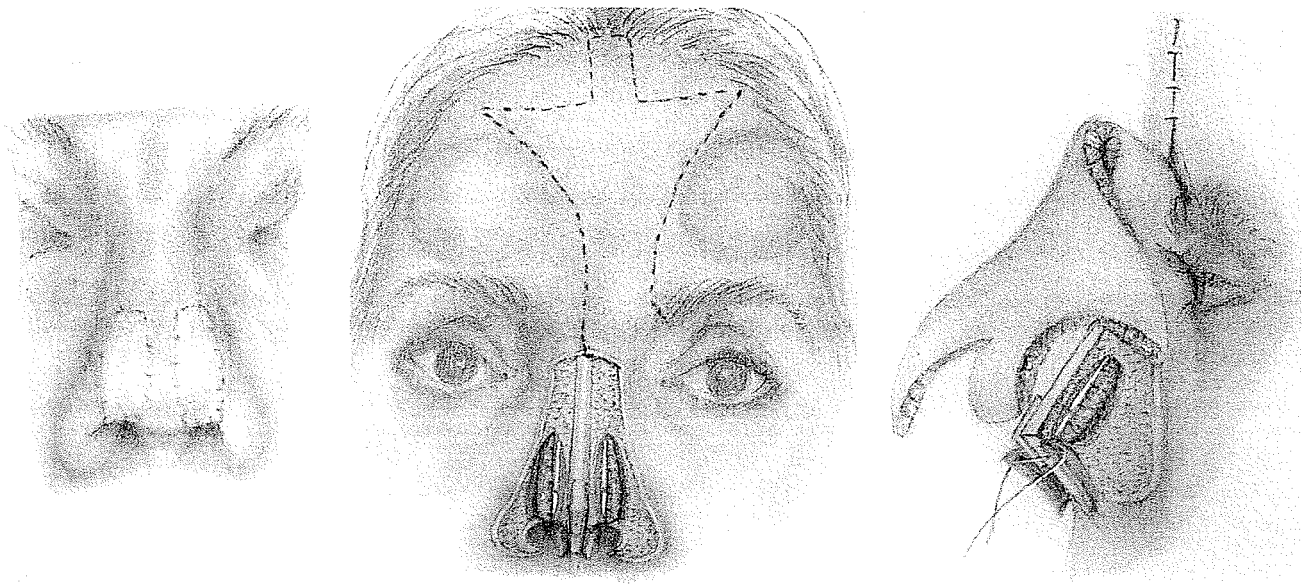
Not being able to tug on the ala, look into the vestibule, palpate the bridge and tip or feel the septum, limits the scope of my specific knowledge about this case. Experience does make it possible for me to estimate a good percentage of what I have not felt or seen. On this basis I have diagrammed a plan.

The nose has been so abused that it has shrivelled with loss of profile, contour, definition and units. As the entire nose has shrunken in scar I imagine that the lining may be short. If not, then the proposed first stage can be bypassed. As the overall reconstruction will plan a one-piece forehead flap cover, the present nasal cover can be discarded or partially used to turn in to supply a more generous vestibular lining. This can be accomplished by a through and through incision on either side of the septum to allow the turn-over of two skin flaps each 1–2 cm wide to open the vestibules. These turn-over flaps are sutured into position and the raw dorsal surfaces created can be covered temporarily with split skin grafts. At the same time a vertical, midline seagull shaped forehead flap based on the left supratrochlear vessels and measured by pattern, can be delayed



by incisions. Two 50 c.c. expanders are placed bilaterally under the unused forehead skin. Expansion is begun.

Two weeks later all skin covering the nose including the skin grafts is discarded. The skin of the retracted columella should be split down its center and the edges turned out. A costal cartilage hinge graft is now placed down the center of the bridge with the L angle at the future nasal tip and the anterior prop tucked into the columella split to rest on the nasal spine. A thin shaving of cartilage can be laid along each ala. Then the forehead flap is elevated, thinned carefully of excess galea and brought down to cover the entire nasal unit. The expanders are removed and the forehead donor area closed with care along natural lines.



Three weeks later the pedicle can be divided and returned to the glabella area to symmetrize the brows.

After a couple of months, when I had heard nothing, I called Maillard. He was extremely appreciative of the diagrams and was thinking over the possibility of carrying out this reconstruction. He explained to me that the patient was a bit frightened at plans of such extensive surgery so he did a face lift and she is very happy at the moment. When she asks about her nose again then he plans to go ahead with our plan . . .