Personal Introduction

I will tell you where I am coming from so you can evaluate where we will be going. If you have no interest in *why* and only want to know *how,* turn to page 1.

From our genes we get our traits and talents and from our early happy associations we develop our ideas of beauty. My father was a small southern town lawyer with integrity and persistence and no artistic talent. My mother was intelligent, skillfully artistic, and beautiful (Daisy Chain, Vassar College, 1915).

I enjoyed art classes in preparatory school and later took charcoal portrait sketching under Conway at Washington University in St. Louis, while studying at Barnes Hospital, and a night course in sculpturing at Wayne State University, while studying in Detroit.

My first exposure to corrective rhinoplasty was as an assistant resident to Beverley Douglas at Vanderbilt University Hospital. Douglas was an inventor and a genius, but he was also a meticulously slow surgeon. Impatient general surgical residents at Vanderbilt dreaded scrubbing on plastic surgery cases. One resident, William Meecham, later to become a famous neurosurgeon, faked a grand mal at the scrub sink and was excused from all plastic surgery cases that week. Another resident regularly autoclaved the morning paper and quietly sat reading it while Douglas puttered along on some intricate case. During my first nose case with Douglas, he removed a hump and carried out other minor corrections for a quite satisfactory result. The fact it took him approximately eight hours could be explained by his meticulous technique and because he did not do a lot of noses.

This experience impressed on me the possible difficulties in rhinoplasty. Being intensely interested in plastic surgery and feeling quite slow-witted at this stage, I welcomed the time to get acquainted with the specialty. Besides, I could bask in the temporary popularity incurred among surgery residents when they knew they could pass their plastic surgery scrubs off on me.

In London in 1948, I observed Sir Harold Gillies do a number of rhinoplasties as he linked principle to procedure and was especially excited by Sir Archibald McIndoe's showmanship and classic technical style in corrective rhinoplasty. I got to do my first corrective rhinoplasty at Rooksdown House in Basingstoke, England, in 1949. Attending surgeon John Barron stood at the back of the room in whispered discussion with a colleague, leaving me free to more or less operate. Occasionally he would call, "Ralph, have you remembered to do the osteotomies?" At Barnes Hospital in 1950, I assisted Louis Byars, observing his smooth technical ability in rhinoplasty, but I was even more impressed by James Barrett Brown's rhinoplasties because of an additional touch of artistry. When he finished a nose and had pressed it to its final shape before placing the splint, Brown always emphasized that if the nose has been done correctly it would retain in healing the corrections observed on the table at the end of surgery.

The second half of 1950 I spent with Claire Straith in Detroit. He did two or three noses a day at $275.00 a nose. He used a profilometer to measure the preoperative nose and to estimate the postoperative result. He made a preoperative plan list of procedures such as hump removal, osteotomy, lower lateral cartilage reduction, anterior septal resection, SMR, and turbinectomy, which he checked off and used *rigidly* to guide him during surgery. It was always a nagging concern of mine what might happen if the wrong checklist inadvertently arrived in the O. R. with the patient! Straith was a remarkably efficient technician. He did not suture the

lining, depending on nasal packs to maintain repositioning, and thus got an occasional synechia. He averaged 20 minutes for a corrective rhinoplasty and submucous septal cartilage resection but his record was *seven* minutes in one case! This concentrated exposure in multiple rhinoplasties familiarized me with the procedures. He allowed me to do secondary surgery on some of his cases and primary rhinoplasties at very reduced fees on any patient I could bring in to surgery. Thus, I spent many a night at dance halls rhumba-ing with the larger-nosed ladies. Occasionally I would have to duck a slap, but more often it was possible to convince them that corrective surgery was in their best interest.

Of all those I observed reshape a nose, however, it was Gustave Aufricht of New York, a student of Joseph, who impressed me the most. A true aesthetic surgeon with autocratic control of the patient and the operating room, he avoided thick-skinned noses and took on only those cases with the possibility of an excellent outcome. He demonstrated practiced, meticulous technique resulting in fine artistic results. There was absolute quiet in the operating room during surgery, but at the completion of the operation Aufricht would invite questions from the observing surgeons. When he asked me if I had any questions after my first time in his operating room, I admitted I was so impressed I would need time even to think of something to ask. We became good friends.

In 1951 as the first chief resident of plastic surgery at Baylor Medical School, I got further experience when a few of the young doctors and nurses at Jefferson Davis Hospital were kind enough to allow me to correct their noses.

When I returned to England in 1952 to write *The Principles and Art of Plastic Surgery* with Sir Harold Gillies, I accompanied Sir Harold on Tuesdays to Harley Street in London. Bored with his own secondary nasal deformities, he let me take on his secondary nasal corrections in the adjoining operating room.

Over the years it has been my good fortune to observe other rhinoplasty surgeons at work. They have included Tom Rees, Ivo Pitanguay, John Lewis, Jack Sheen, George Peck, and Richard Straith and from each I learned something of value.

It was also my good fortune to have part of my training at Rooksdown House, Basingstoke, England, just after World War II while many of the noses severely deformed by bullets, shrapnel, and burns were going through the process of reconstruction. Gillies taught me the use of the forehead flap and the tube pedicle. Then at Barnes Hospital in St. Louis I learned from Brown the art of composite ear grafts to repair alar margin defects and many years later observed Dan Baker's modification of the composite auricular graft with extended preauricular skin for larger alar margin defects.

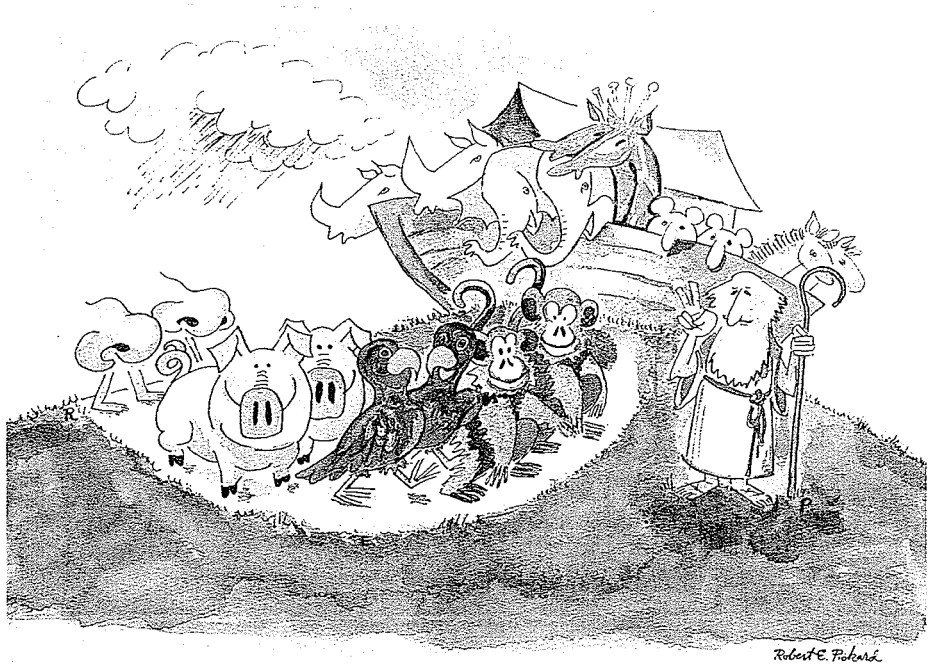
In Korea, as chief plastic surgeon to the U.S. Marines, I had the opportunity to reconstruct Korean nasal deformities resulting from war casualties.

This is briefly the rich but multifaceted background that more or less prepared me to undertake some difficult nasal deformities. I have been willing to take on all cases if the patient seemed psychologically sound. This explains the variety displayed here.

In Biblical history Noah is reported to have built an Ark in preparation for the great flood. Then he collected all animal species and marched them into his Ark, two by two, not only to save them from drowning but to enable them to carry on their species after the flood.

As I have been collecting my cases for this book, so many came in pairs I began to feel a little like Noah. Although under no pressure to get a male and a female, often I have done so. Not confined quite so much for space, it has been possible to bring on more than a pair of examples of numerous problems along with their varying solutions.

When I think back over the work hours involved in all these cases and many, many more devoted to the planning, the actual surgeries, and the postoperative dressings and care,



I get a little weary. A few were routine, many were taxing, some exciting, but most were challenging. Here they are for what they are worth to you and your patients.