

35. Congress Demonstration

IT was not long after Berkeley's provocative visit to Miami that I was scheduled to demonstrate over live TV a cleft lip closure at the Fifth International Congress of Plastic Surgery in Australia. When the preoperative photo of the severe cleft that O'Brien had saved especially for me arrived, I began looking at travel folders for a February holiday in Alaska. Yet the temptation to go for a primary nasal correction without external scars at the time of the lip rotation and advancement was too great. I postponed a trip up the Yukon and headed down under.

The time was the hour and a half at the opening of the International Congress on the morning of the first day, February 22, 1971. The place was St. Vincent's Hospital, Melbourne, Australia, before the color television cameras with 14 viewing sets at the Masonic Centre for the international membership. The patient, 11 weeks old and having wide unilateral cleft with severe nasal distortion, was "kindly" presented me by Bernie O'Brien, who also masterfully engineered this first color TV medical presentation in Australia.

The panel of opponents which had been collected included Skoog, Johanson, Manchester, Randall and Davies, and these were partially buffered by a gentle moderator, Bill Lindsay. In my opening remarks, I explained that if I were back in Miami on such a *wide* and *difficult* cleft patient I would use a small adhesion at one to two weeks of age, let this mold the maxilla and then at five to six months do a vomerine flap closure of the hard palate as Manchester advocates, an alveolar cleft closure with possibly a Skoog periosteal flap and then a rotation-



advancement closure of the lip. With the nasal structures less delicate at six months, the more radical correction would be facilitated. As this was not Miami, there was no time for adhesive action.



With one of Benny Rank's top registrars, Felix Behan, as assistant, I proceeded to do the rotation-advancement, emphasizing the back-cut. Then we launched into a radical nasal correction. The incision which freed the lateral lip from the maxilla was extended in the usual fashion in the vestibule along the intercartilaginous line of the nasal lining to free the abnormal attachments of the alar base. In this case this incision was carried around under the tip and joined the membranous septal incision previously started from below for the advancement of flap c into the columella. The alar cartilage was freed by undermining from the skin, and the skin was also freed from the septum at the tip. A white 4-0 nylon suture picked up the slumped alar cartilage at the junction of medial and lateral crus and stitched it up onto the septum and to the opposite alar cartilage. The first tie-up was not quite right, and Hector Marino was heard to whisper among the spectators,

He will take this one out.

The second attempt at suture placement finally did sit the nose up nicely.

The remainder of the operation went smoothly, as previously described in publications, but with special attention to possible queries from the panel. I had the benefit of John Hueston remarkable pre-Congress publication of the *Transactions* and knew what my friend David Davies was thinking and probably planning to say. Davies had already acknowledged in the 1971 *Transactions*,

Finally, the Millard repair. Almost certainly the most commonly used today, it is presumptuous of me to criticize it but no method is as yet perfect and one must be prepared to discuss its flaws. The line diagrams are simple, the logic flawless, the concept brilliant; but many of us struggle to execute it . . .

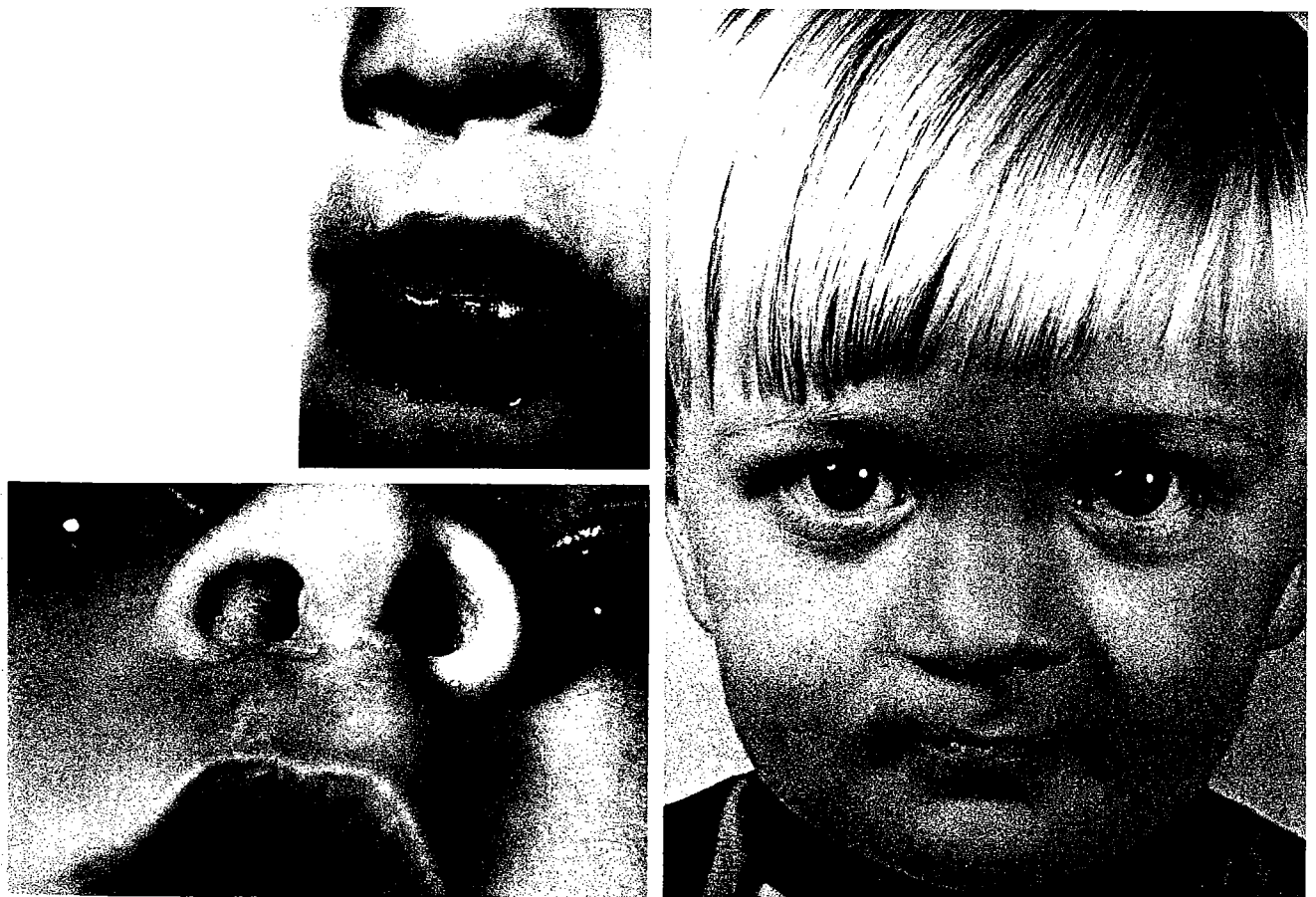
What he was saying was that it looks good on paper but the free-hand fiddling may be difficult. In the *Transactions* he had pointed

to an attenuated medial element which occurs in some cases but need not be a problem. Davies emphasized another flaw:

A factor that I find disturbing is the approximation of two convex curves which appears to leave the majority of the bulk in the centre of the lip and not on the lower rim.

This can be troublesome, and so, during the Congress operation I made a particular effort to demonstrate fashioning the lateral lip element concave to fit the convexity of the medial component. It seemed to go well.

Then, on the fifth and last day of the Congress, after suture removal the baby was brought back on TV for a final show. The nose, lip and baby behaved so well before the cameras that a "hand of applause" was requested and received for this future actor. Recently, O'Brien sent me the 21-month follow-up photographs of the Congress cleft lip baby with a report that the palate had been closed and all was well.



After my cleft lip operation in Melbourne, Musgrave informed me that he had been most interested in this demonstration, but it was not until I read his and Garrett's section in Goldwyn's 1972 book that I understood his reference.

The most dramatic improvements in the correction of severe nostril defects in the wide complete cleft lip have been recently observed in Millard's personal application of the rotation-advancement principle, wherein attention is paid to both the medial and the lateral alar crus. The medial crus is elevated in the upward swing of the composite columellar pedicle, and the lateral alar cartilage is advanced medially and upward to simulate the dome effect of the opposite alar cartilage.

Let us say that at this specific time in the evolution of cleft lip surgery the rotation-advancement principle would seem to be generally accepted. There are those who follow the original design. There are those who have adjusted to the refinements and extensions. There are those who use the principle but "do their thing" with some little modification which is of benefit in certain cases. This is my general approach, always trying to improve in the detail as with the refinements or nasal correction at the Congress. There are other surgeons with the same motive, also trying to improve the final results.

LOOK OUT FOR THE BACK-CUT

One afternoon of the Melbourne International Congress was spent at Emu Bottom, the oldest homestead farm in the area. Here dogs demonstrated their skill at herding sheep, champion woodcutters competed with their axes chopping through logs of equal girth, wool was shorn and unleavened bread was served. Then, out on an open sloping field, boomerangs were offered. Lessons given in the position of the hand and the angle into the wind to throw soon challenged the plastic surgeons. The Australian surgeons were conspicuously absent, being fully cognizant of the hazards of a novice with this sharp, flat, curved stick, for if accurately thrown it will in truth "cut back" to the thrower without concern for those within the arc. Cleft lip and palate surgeons were notably present—optimistic, energetic, per-



fectionist, competitive and determined to master every detail of the technique. Among the throwers were Bengt Johanson, Ivo Pitanguy, Ed Schmid, Rudy Meyer, Theo Wilkie and myself, each ducking the other's boomerang when not trying to get out of the way of his own. Tord Skoog watched wisely from high on a hill. The winner—the surgeon getting the boomerang to return the closest to him the greatest number of times—was Wilkie of Vancouver, and this outcome was pleasing, for he has long been using the rotation-advancement method effectively, as he described in 1969.

