

postoperative outcome. The use of the alar rim graft, however, was not to decrease the cleft-side nostril width. The inquiring authors suggested malpositioning of the labial and philtral muscles as the main contributing factor of the nasal deformity described in this article. We would like to clarify that all patients included in our study had adequate muscle dissections and mobilization of the perialar and philtral musculature to reestablish appropriate muscle orientation and function. There was no significant difference in cleft-side nostril width between the two groups of patients in this study. Our techniques of primary cheiloplasty with muscle dissection and repositioning have been described in Neligan's *Plastic Surgery* textbook² and the Noordhoff Craniofacial Foundation's instructional DVD.³

The inquiring authors also raised the concern of harvesting a 0.5 × 2-cm septal cartilage from the caudal portion of the nasal septum with regard to facial growth. They commented that a 0.5 × 2-cm septal cartilage rim graft was insufficient in size to support the nostril shape when these patients reach adulthood. The use of a primary septal cartilage rim graft was to provide better nasal symmetry and aesthetic as they grow throughout childhood and early adolescence. Whether these patients need secondary cheiloplasty or rhinoplasty as they reach adulthood is still unknown. Although a septal cartilage graft is unlikely to proliferate after being transplanted to the recipient site, cartilage graft has been shown to remain viable with minimal graft resorption based on histologic findings reported by several studies.

With regard to the donor-site defect, we performed a limited subperichondrial dissection at the caudal aspect of the septal cartilage at the time of graft harvesting. The perichondrium surrounding the donor site remains intact. Whether the donor-site defect fills in with chondral matrix that eventually matures into cartilage is still unknown. This certainly warrants a separate investigation by computed tomographic or magnetic resonance imaging studies when we follow these patients long term to evaluate their facial growth and surgical outcomes.

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Principles of Cleft Lip Repair: Conventions, Commonalities, and Controversies

Sir:

We read with great interest the article from Marcus et al. entitled “Principles of Cleft Lip Repair: Conventions, Commonalities, and Controversies.”¹ The authors describe the evaluation and management of unilateral and bilateral cleft lip (with or without cleft alveolus and with or without cleft palate) in a very comprehensive review.

They underscored the work performed by Mohler regarding the description of the anatomical variants of the philtrum.² In clinical practice, we also realize that we found many vertical philtrum columns, rather than curvilinear philtrum columns. The philtrum is one of the most important anatomical structures in the preoperative evaluation of the patient. Philtral anatomy is a complex relationship between components of orbicularis oris muscle and overlying dermis. For unilateral cleft lip repair, eversion of orbicularis oris muscle is necessary to build a philtral ridge.³

In our opinion, among the various surgical techniques reviewed by Marcus et al. for the unilateral cleft lip repair, the Fisher technique allows the maximum respect of the philtrum—in particular, the column proximal to the cleft.⁴ As Fisher reported, the technique derives from a variety of previously described repairs and adheres to a concept of anatomical subunits of the lip. The repair allows for a repair line that ascends the lip at the seams of anatomical subunits, with the almost total respect of the philtrum column.

Another crucial aspect is the reconstruction of alveolus cleft, through periosteoplasty.⁵ The technique described by Massei guarantees the preservation of vascular supply and the osteogenic activity of the periosteum, with satisfactory new bone production.

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Simplifying the Forehead Flap for Nasal Reconstruction: A Review of 420 Consecutive Cases

Sir:

We read with great interest the article entitled “Simplifying the Forehead Flap for Nasal Reconstruction: A Review of 420 Consecutive Cases” by Sannic et al.¹ in a recent issue of *Plastic and Reconstructive Surgery*. The authors’ retrospective analysis of patients who underwent nasal reconstruction was exemplary for plastic surgeons, especially the plentiful practical details about postoperative care and operations on senile patients. In this communication, we would like to propose our different experience and perspectives for the same group of patients, and that could be conducive for popularizing these techniques.

Initially, the authors preferred the ipsilateral flap design over the Parkland design for the consideration

of hairline and scar. However, the expanded forehead flap has gradually become our first choice in recent years by the same token, and it can avoid secondary closure in both the donor site and the pedicle, which could be more treacherous in non-Caucasians, who have a tendency to scar. Actually, the tissue expansion would not lead to too much negative impact on the patient’s daily work and life, provided that appropriate tissue expansion is performed and it fits the whole operative procedure with regard to the patient’s work and study calendar well instead of merely the surgeon’s convenience. In addition, there is no need to worry about the hirsute flap because they are the source of rhinothrix and moustaches, especially for male patients who need philtrum reconstruction at the same time. Also, laser hair removal is recommended. Meanwhile, some patients plucked their hairs on the flap and did not complain of pain of incomplete neurotization.² Thus, the hair is not a decisive factor affecting this flap option.

As regards using a framework and staging surgery, it strongly contrasted with our experience that costal cartilage was used in only 1 percent of patients among the 57 percent who underwent cartilage grafting. We never hesitated to harvest costal cartilage for the framework, because solid supports provide rigidity to the sidewall and resist lateral collapse during inspiration. Sometimes, grafts are necessary to be placed in areas that do not contain cartilage from the anatomical perspective to establish fluent contour, reduce notch, and prevent cephalic retraction of the alar margin. Also, adding a piece of cartilage onto the nasal dorsum to enhance height could improve the aesthetic outcome for the majority of Asian patients. That means we need a versatile cartilage, both in quantity and in quality (e.g., to take advantage of the elastic costal cartilaginous cortex for the nasal alar margin grafts). However, ear cartilage is fixed by its natural configuration and there is little that can be done to shape it.³ Thus, we prefer costal cartilage rather than ear cartilage, and a three-stage flap is more amenable than a two-stage flap with simultaneous cartilaginous framework placement.

Finally, the authors’ thorough educational process for patients met on the day of surgery is admirable. Although we insist on the importance of careful planning and psychological preparation, which cannot be overemphasized, we need to practice introspection to improve our efficiency. In the end, we thank the authors for standardizing the procedures of nasal reconstruction and providing us with a comprehensive understanding.

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