technique is that since thickness of remnant breast issue is felt by bimanual palpation (rather than guessing) the chances of error are less. Moreover slight amount of unevenness on posterior breast is masked by breast tissue lying over it and is less noticeable.This modification also reduces the unevenness which is more evident with superficial excision.

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## IS PRIMARY RADICAL NOSE CORRECTION REALLY NECESSARY?

Sir,

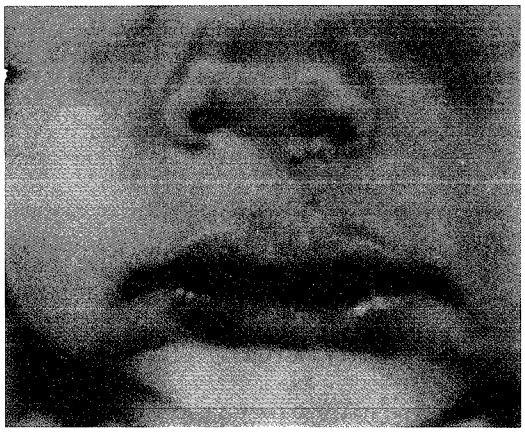
"Always searching, never achieving perfection" is very apt for those of us who have surgically treated the cleft lip patients and experience continued frustrations with the aesthetic results of primary surgery. I have approached this problem for the past 2 years and have found continuing satisfaction.

The nose is the single most challenging component of the cleft lip complex, based on the view that the nasal deformity is secondary to the abnormal forces acting on the alar cartilage. I attempted nasal correction exclusively by extensive muscle mobilisation and nasal floor repair. This has been found adequate for a good aesthetic appearance of the nose in most cases.

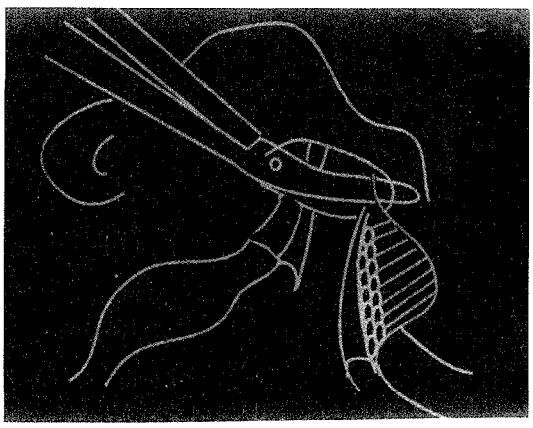
To Millard's technique the following modifications were added

1. Rotation flap does not curve under the columellar base, but follows the direction of the philtral column on the non cleft side, so as to preserve the natural ridge of the lip. Lateral advancement incision does not curve under the alar base as the radical dissection of the muscle carries the alar base inwards. C flap is inserted across the nostril sill and not used for columellar lengthening, there by providing an adequate tissue for nasal floor closure (Fig 1 & 2).

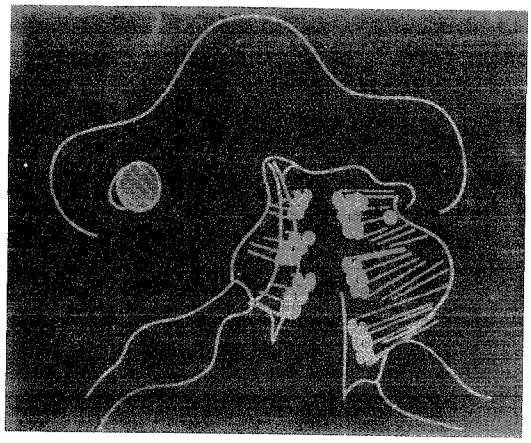
(Fig - 1) Pre-operative view



(Fig - 2) 5th Post operative day



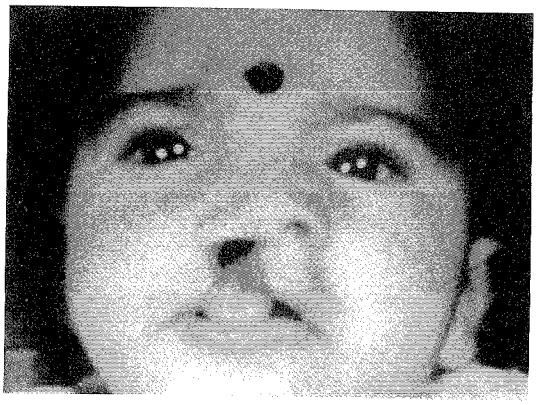
(Fig - 3) Muscle backcut



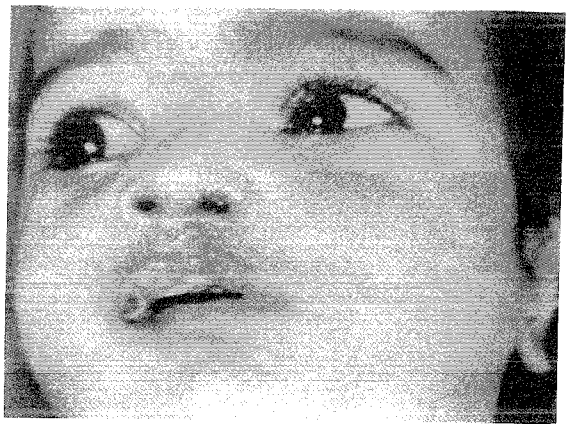
(Fig - 4) Muscle split to interdigitate

2. Radical muscle mobilisation was done with back cut around the alar base on the lateral side and towards the nasal spine on the medial side, muscle flaps split into three separate bundles, and interdigitated to lengthen the muscle both in the vertical and horizontal direction (Fig 3 & 4).

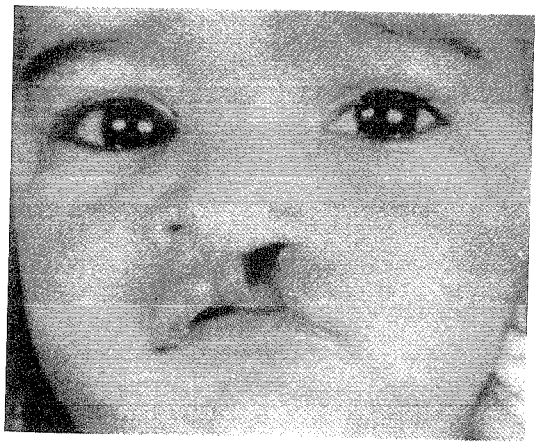
3. Primary closure of the nasal floor and anterior palate was effected by approximating mucosal turnover flaps from the vomer to nasal mucosal flaps laterally. For better symmetry of alar arches trimming of the alar rim was carried out when there was redundancy of skin at that site. In some cases the alar cartilage was mobilised from the skin and the mucosa without any direct vestibular incision (Fig 5 & 6).



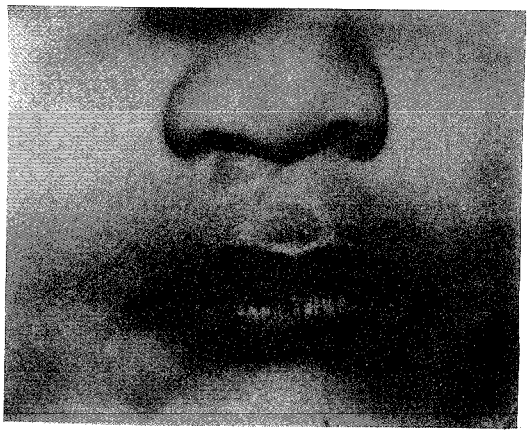
(Fig - 5) Pre-operative showing redundancy of alar rim



(Fig - 6) Post-operative showing trimming of alar rim



(Fig - 7) Pre-operative view



(Fig - 8) Post operative - final result.

To obtain a perfect result in one operation is hard to come by. But a reasonably good result is achieved by this technique which is simple and takes only a few extra minutes. The alar cartilage is repositioned by simple scissor dissection from the overlying skin and lining mucosa through lateral advancement incision. This dissection along with the radical muscle mobilisation obviates the need for a radical procedure for nose correction (Fig. 7 & 8).

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