

Gillies Oration*

Brigadier R. Ganguly**

Ladies and Gentlemen,

I am extremely grateful to the Association of Plastic Surgeons of India for the great honour they have done me, by inviting me to deliver the Annual Oration in memory of a person of Sir Harold Gillies' eminence, who has been universally acknowledged as the "Father of Modern Plastic Surgery".

All the past Presidents of our Association who had delivered this Oration during the previous years, were Plastic Surgeons, who had the privilege of coming into intimate contact with Sir Harold and received training from his hands. But most of you will be surprised to know that I have been invited to pay tribute to this legendary figure, whom I had the opportunity of meeting only once in my life time. In honouring Sir Harold Gillies, I will not be presenting before you any original work of mine, simply because I have no claim for originality in my works. I have decided only to give you a glimpse of my experience of a "Decade in the Company of Plastic Surgeons".

In early 1946, I had returned from Service with the Middle East Forces and joined 7, Indian Base General Hospital at Kirkee near Poona, for my Specialist Grading

in General Surgery. For the first time I came in close touch with the Maxillofacial Surgery Unit, attached to our hospital, where Captain Balakrishna and Captain Sukh were being trained by Major Gibson in the art of raising of skin flaps and tube pedicles, to provide cover for war wounds. But, "Skinning". I thought was a speciality which was likely to deflate my ego as a General Surgeon.

Ten years later, i. e. in December, 1956 when Sir Harold had already completed the inauguration of the Plastic Surgery Section of the Association of Surgeons of India, I was roaming the streets of London still undecided about a suitable field for further specialization. Some one suggested that I should go for "Plastic". But frankly speaking, even in those days, "Plastic" was a speciality which failed to stick to my head or hold any lure for me. So, while in England, instead of visiting Sidcup, Bassingstoke or East Grinstead, I decided to go to St. Barth's where Sir Harold had received his Medical training, - but it was not to learn the techniques of Skin graft, but to be initiated into the art of Vascular Grafts.

Sir Harold came to India again in 1958 and paid a visit to Military Hospital Poona—

* Oration of Summer Conference of Association of Plastic Surgeons of India.

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where I was a full-time General Surgeon and Major Sukh was - what you may call a "Pedigree Plastic Surgeon". One fine September morning, I was in the procession of doctors who were trailing behind the distinguished visitor from England. True to the spirit of Gillies, my dear friend Sukh believed in the Gospel—"Never do to-day what you can put off till tomorrow". The inventor of the "tube of living skin" from Sidcup was thrilled to find a galaxy of tube-pedicles hanging from various parts of the body of patients who had been enjoying their hospital stay for months and years.

I followed the old man from bed to bed, watched him, demonstrate to Sukh, plans for reconstruction which could cut short hospital stay for his patients, and enjoyed, as an onlooker, the little jokes and humours by which the great man was not only pulling his legs but also paying him compliments for some of Major Sukh's very good works.

Little did I know at that time what was in store for me. Within a year after Sir Harold left India, our Plastic Surgeon was posted out of Poona and I was asked, to look after his cases in addition to general surgical work. You can well imagine my plight, saddled with all sorts of reconstructive problems, with no formal training to go by, no text books to guide, and no one to look to for advice. For the first time in my life, I sincerely felt an intense longing for the grand old man with glasses resting on his nose ever-ready to teach any young man who was prepared to take his advice. As I was seriously thinking of going back to U.K. to contact the old man, to fix me up somewhere

for training, I accidentally met Benny Rank, the doyen of Plastic Surgery from Australia.

Rank had come to Poona in December, 1960 to attend the Annual meeting of our Association of Surgeons. He listened to my first ever paper on Plastic Surgery, based on the Salvage work I had carried out on the cases, my friend Sukh had heaped on my shoulders. Rank expressed a desire to visit my unit, but, as I was proudly showing him round my ward in the hospital, he politely remarked that, I was doing good work in my own way, but could benefit a lot with a bit of training from a Master. I told Rank about my plans to approach Sir Harold,—the only Master I had known since then from the world of Plastic Surgery. But Rank sadly informed me that Gillies, the great pioneer, was no more. The Grand Master had died in London, just about three months back,—on the 10th September, 1960. Benny Rank cheered me up by mentioning that he was one of those overseas Surgeons, whom Sir Harold had trained during the War, and that he was not only "Gillies Man" but came from a beautiful part of the world, which was closely linked with New Zealand,—where Sir Harold was born and brought up in his childhood. It was Rank who suggested that I travel East for a change. Before the end of the year I landed at Sydney, on my way to the Royal Melbourne Hospital, for training in Plastic Surgery under the Colombo Plan.

For me it was a memorable visit to a friendly country. I thoroughly enjoyed for weeks the hospitality of Mr & Mrs Rank and the rest of the Rank family. I enjoyed the

quiet afternoons spent in the company of Mr and Mrs Hueston and the intimacy of their very friendly children. But in between the long drives along the Pacific Coast in the company of my Australian Friends, there were Plastic Surgery Sessions too, both in the public and Private Hospitals of Melbourne. In public hospitals, I learnt to transfer scalp flaps to the cheek, Abbe-flaps to the upper lip, Estlander flaps to lower lip and Visar flaps to the chin. In private nursing homes, I tried my best to grasp the technique of repair of cleft lips, correction of bat ears, rhinoplasty for hooked noses, and mammoplasty for pendulous breasts. For the first time I realised that there was not only so much to learn in this specialised field of Surgery but so much more to observe in the beautiful land where I had landed by force of events.

I left Australia in 1962 and returned to India with lots of enthusiasm for Reconstructive Works. Though there were not many pendulous breasts I could lay my hands on, there were plenty of cleft lips and palate to tackle. I started with grown ups where the going was good, and slowly switched on to younger children, and then to still younger children and infants. I soon realised that in Group II clefts, there was no difficulty in the repair and lengthening of the palate, and in Group I clefts - no difficulty to get a satisfactory closure of the lip but in Group III clefts of lips and palate one had to turn the face of the child slightly to the affected side, to hide the minor degree of buckle and flare of the ala that remained, after meticulous repairs in the best of hands.

I faced the common problem of hypospadias where I seemed to be invariably running into difficulties. To avoid urinary fistulas, I thought it safer to carry out multi-staged procedures- of initial correction of chordae, followed by diversion of urine, outlining a strip into an urethral tube, temporary burial of the tube into the skin of scrotum, and the final separation of the penis from the scrotum, so that the child could void a good stream of urine through a new meatus under the glans. The results were not perfect but even in grown-ups the same procedures were followed without any difficulty, and with satisfactory functional results.

Then there was the usual problem of burns needing split grafts, contractures of axilla needing Z-plasties for correction, or contractures of neck which could be released by free grafts or demanded pedicle flaps for their correction. Occasionally there were gross deformities of hands requiring transfer of abdominal flaps for complete restoration of their functions.

In 1962 hostilities broke out with China and we were flooded with casualties. There were demaged feet requiring thigh-flaps for cover, compound tibias requiring crossflaps from opposite legs and compound ulnas requiring open flaps from the abdomen. There were occasions when I used, Gillies abdominal tubes to save badly shattered legs, and there were occasions when to save time jump-flaps from abdomen were shifted to injured legs to put soldiers back on their feet.

Then there were paraplegics with big

sacral sores, who needed rotation of gluteal flaps for proper healing of the necrosed areas, and paraplegics with conical ischeal sores who needed excision of the underlying tuberosity with rotation of thigh flaps for permanent healing of infected bursal cavities so that the individual could be put back on his wheel chair. Then there was also the problem of Maxillo-facial injuries. I used scalp flaps for upper lips, Midline forehead flaps for the missing nasal tips, and for total loss of nose lateral forehead flaps to make a new nose and iliac bone grafts to support the bridge.

For traumatic paralysis of the face we used Gillies temporalis muscle sling for the Eyelids, masseter muscle slings for the lower face and mouth, to achieve closure of eyes and satisfactory muscle balance.

Long after the hostilities stopped, we had time to relax, and some respite from the unending stream of battle casualties. I moved into other fields and tackled a series of cases of ankylosis of T.M. Joint. We used the preauricular incision to expose the condylar region, carried out wide excisions of the bony blocks, packed the cavity with spongistan, encouraged early movements with bite blocks and training flanges, and achieved very satisfactory opening of the mouth. We tried the same procedure on many other children and achieved uniformly good functional and cosmetic results.

Sir Harold Gillies was the first person to emphasise the importance of Dental Collaboration in Plastic Surgery. I was fortunate to have an efficient Oro-dental Surgical Unit with me. With the help of my

enthusiastic colleague, we also tackled a series of cases of mandibular prognathism. We carried out vertical osteotomy of the mandibular ramus on either side, decorticated the outer surface of bone, and then set the mandible to the desired level, before immobilising the jaw with pre-fixed splints and wires to achieve proper dental occlusion and satisfactory cosmetic results. The same procedure was used even in marriageable young girls with results acceptable both to the girl and her parents.

By the time War broke out again across our Western Frontier. I had succeeded in establishing a properly staffed and equipped Plastic Surgery Unit at Poona—and could depend easily on my junior colleagues, whom I had the privilege of training, for all the routine works of reconstruction.

I took up for myself the problem of reconstruction of amputated thumbs. I used the usual tube pedicles to create skin thumbs, provided the necessary support by iliac bone grafts, transferred neuro-vascular island flaps for sensation and created thumbs which could be used not only for holding glasses but also for writing letters. Where patients were prepared to spare a mutilated digit, I pollicized the same with care to preserve the neurovascular bundle, so that the patient had a new thumb with satisfactory functional results. In patients with amputated thumb and a good index finger without its metacarpal, I could pollicize the useless index to give the patient a new thumb with useful function.

Following cease-fire of the Indo-Pak conflict, there came another period of peace and time for celebration. A centre for the

treatment of malignant diseases was established in our hospital and I shifted my interest to surgery of Oral Cancers. For hypertrophied growths of the lower lip it was rewarding to carry out wide excision and reconstruct the defect with a Estlander's flap, completing the repair in one stage. For growth involving small areas of the cheek, defect left after full thickness excision, needed islandflaps of forehead skin for lining, and rotation flap of cervical skin for cover, to complete the repair and achieve fairly satisfactory one stage reconstruction. Growths of the cheek which had involved the alveolus, needed monoblock excisions of cheek, mandible and floor of the mouth and suprahyoid block dissections of the neck. For immediate reconstruction of the defects, I usually preferred to use the forehead flaps for lining and rotated cervical flaps for cover. For very similar growths requiring excision, of the same magnitude, the defect was often corrected by using a tongue-flap for the lining and a cervical flap for cover. For advanced growths of the floor of the mouth which had fungated through the chin, very wide excision of lip, chin, mandible and submandibular region of the neck resulted in hideous deformities. But a marsupial-flap carried on the forearm, provided the tissue immediately needed to give the patient a socially acceptable face.

For intrinsic growths of the larynx, total laryngectomy and block dissection of the affected side of the neck, permitted immediate closure of the pharynx, so that the patient could swallow liquids in a reasonably short time. But where the growth had involved the pharynx cancer clearance often demanded total laryngo-pharyngectomy and

block dissection of the neck leaving a permanent tracheostomy, with the oro-pharyngeal opening above, and the oesophageal opening below. For reconstruction of a new pharynx, I used the neck skin for lining, and a tubed cervical skin for cover, to complete a satisfactory repair in reasonable time so that the patient could resume swallowing of food and drinks and lead a fairly normal life. Ladies and Gentlemen in spite of my flirting with plastic surgery, I could not completely dissociate myself from my first love that was General Surgery. That is why, when the occasion came, I did not hesitate to descend from the region of the head and neck into the chest and abdomen to resect segments of cancerous oesophagus and pull the stomach up for reconstruction of a new food passage so that the patient could be saved from total starvation.

But, I can assure you that though I kept deviating away from the beaten track of Plastic Surgery into other fields of reconstruction my association with *Plastic Surgeons* for over a decade had been thoroughly enjoyable. I could welcome you to the Summer Conference at Poona, invite you to visit my unit and critically assess my work. You elected me to the highest office of the association to Preside over the annual meeting and then dethroned me as usual by pinning on my chest the Presidential Medal which I had the privilege to coin myself. My association with Plastic Surgery was also rewarding, because it was on account of my humble contribution in the field of reconstruction for battle casualties, I was decorated by our Supreme Commander—the President and suitably honoured by the Medical Council

through the hands of our Vice-President.

Then it was because of my romance with the speciality popularised by Gillies I got a chance of going back to Australia to revisit Sir Harold's land of origin, attend a spectacular International Meeting presided over by a Gillies' man, who was my teacher, renew my contact with some of my plastic friends, and stand side by side with giants in the profession like Mustarde from Scotland, Skoog from

Sweden, Penn from South Africa, and Millard, one of Sir Harold's close associates from the States. Ladies and Gentlemen, I remember with reverence "Twentieth Century's Surgeon Extraordinary" and pay my personal homage to the Master, who, by a chance meeting, on a September morning, initiated me into the world of Plastic Surgery and made it possible for me to have a meaningful professional career.

Thank you.