DOUBLE-SIDED PALATAL ATTACHMENT OF THE SUPERIORLY BASED PHARYNGEAL FLAP

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The superiorly based posterior pharyngeal flap has gained wide acceptance as a useful technique, for the correction of velopharyngeal incompetence. There are, however, technical problems involved in suturing it in place and later partial or total dehiscence may occur, perhaps, as Skoog (1965) suggests, because of the contracture of the healing raw areas.

The technique to be described is simple to perform, gives secure fixation of the flap and does not entail reopening the soft palate cleft.

TECHNIQUE

After designing the flap, the posterior pharyngeal wall is infiltrated with normal saline injected through a long thin needle. The superiorly based flap is elevated in the

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Fig. 1. Diagram of the preparation of the denuded superiorly based pharyngeal flap. (A) Soft palate, (B) de-epithelialised pharyngeal flap, (C) the epithelium dissected off the flap.
FIG. 2. (left) The elevated pharyngeal flap, held by 2 stitches after being denuded of its epithelium over the distal two-thirds.

FIG. 3. (right) Undermining and splitting the soft palate into oral and nasal layers. Undermining should reach as close as possible to the bony margin of the hard palate.

FIG. 4. (a) The denuded pharyngeal flap about to be inserted in the split soft palate. The hook holds apart the oral layer. (b) The pharyngeal flap has been drawn into the palate by 4 long silk stitches, which are tied after full insertion.
usual way, being held by 2 long sutures at its distal corners. By means of delicate sharp curved scissors, the mucosal epithelium is dissected from the flap (Figs. 1 and 2). This is not so difficult as it sounds, particularly after infiltration with saline, and sufficient dermis may be retained to protect the vascularity of the flap.

A line is then drawn and incised along the distal free border of the soft palate. With the same scissors the soft palate is split into an oral and nasal layer (Fig. 3). The denuded pharyngeal flap is inserted into the pocket thus created by means of 4 long 4/0 silk sutures, which are tied on the oral aspect of the soft palate. The distal end of the flap should be close to the posterior edge of the hard palate. One or two additional sutures are fixed at each side of the flap to ensure firm attachment (Figs. 4 and 5).

RESULTS

Eight children, aged 4 to 7 years, have been operated upon in this way for velopharyngeal incompetence; full attachment of the flap was achieved in all 8 with no sign of dehiscence or displacement. An obvious improvement in speech was noticed shortly after operation.

REFERENCE