THE MANAGEMENT OF PERFORATING WOUNDS OF THE PALATE

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A PERFORATING wound of the palate usually follows an accident in which a child falls with a stick in the mouth. The end of the stick usually impinges on the hard palate on which it slides, causing a laceration down to bone. At the posterior edge of the bony palate the remaining force is applied to the soft palate which is usually perforated and sometimes partly torn from its bony attachment. The wound may be a clean-cut perforation but often it is extensive and ragged, presenting a view of the nasal cavity.

Initially bleeding is brisk but spontaneous arrest is usual and the total loss insignificant. If the palatine artery is torn, however, bleeding can be torrential—fortunately this is extremely rare.

Many practitioners and casualty officers who meet this type of injury have no knowledge of the correct method of management. The initial impulse is to try to suture the wound, with or without anaesthesia. This must be avoided because the child is usually frightened and inadequately prepared. As the vast majority of these wounds heal perfectly if left alone and the use of sutures may cause further damage and delay healing, there is no indication to interfere. The prognosis is so good that it is often unnecessary to admit these cases to hospital and the use of antibiotics is not indicated as a routine.

In the rare event of the palatine artery having been torn, continuous digital pressure on the bleeding point and the use of posture and suction to clear the airway are advised, until an anaesthetic can be given. Intubation can be difficult owing to the amount of bleeding, and the simultaneous use of two suckers is helpful. The proximal end of the palatine artery is grasped in straight mosquito forceps and dealt with as in a cleft palate operation, the point of the forceps being gently worked into the adjacent palatine foramen, and the vessel twisted off and allowed to retract into the bony canal.

In one case the wound was caused by a piece of bamboo which broke off in the soft palate. Some months later a sinus from which a piece of wood was removed appeared on the cheek; a second sinus developed later near the tip of the mastoid process. Two pieces of bamboo were removed from the depths of this sinus and healing was uneventful. Exploration of the original wound in this particular case might have prevented further complications.

SUMMARY

The fact that perforating wounds of the palate should be left to heal spontaneously is not widely recognised, although it is well known by those who carry out palate surgery. The prognosis is so good that most cases need not be admitted to hospital. The very rare exceptions, namely patients with a torn palatine artery, or those in whom a foreign body is embedded in the tissues, are mentioned and suggestions made concerning their management. In a review of 12 cases referred to this Department during the last 10 years and treated conservatively, no evidence of permanent damage or fistula formation was found.