DISCUSSION

Elongated Pharyngeal Flap in Extensive Clefts of the
Hard and Soft Palate

by Hans Holmström, M.D., Ph.D., Rune Stenborg, M.D., and Gunnar Blomqvist, M.D.

Difficult problems in the anterior palatal region often require more tissue, and plastic surgeons over the years have come up with many ingenious methods, including distant pedicles, tongue flaps, and buccal flaps. As Holmström et al mention, a superiorly-based pharyngeal flap can be made long enough to provide well-vascularized tissue for the anterior portions of the palate.

During 1975, which I spent with Paul Tessier in Paris, I saw him on several occasions take posterior pharyngeal flaps that reached to the alveolar ridge or beyond. This was done without requiring a lateral pharyngotomy and was performed by use of proper retractor, proper head positioning, good lighting, and in particular, the progressive application of long skin hooks with which the pharyngeal tissue could be pulled superiorly and progressively be cut to provide an extremely long flap. The donor area is closed if possible.

Thus, it is possible to avoid the use of the lateral pharyngotomy, which I think would make this procedure unduly risky and too much of a surgical adventure for some plastic surgeons.

In any event, the procedure may be of historical interest only because of the increasing use of the temporalis muscle for providing vascularized tissue for palatal defects. Tessier deserves the credit for developing this procedure, and I hope that he can be convinced to publish his method in the near future.

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Reply by Hans Holmström, M.D., Ph.D.

As I understand the discussion of Dr. Wolfe, he recognizes the fact that a superiorly based pharyngeal flap can provide well-vascularized tissue for covering anterior palatal defects. The technique, developed by Bengt Johanson in 1957, made use of a lateral pharyngotomy to obtain access to the lower pharynx. This approach is regarded by Dr. Wolfe as too risky for plastic surgeons, and this is why he recommends elongation of a pharyngeal flap by application of traction to the posterior pharyngeal wall, as performed by Paul Tessier. First, I must emphasize that a lateral pharyngotomy is not a complicated procedure provided that the surgeon has a fair knowledge of the topographical anatomy of the neck. All 11 patients reported in this material were operated on by Bengt Johanson, and as an assistant I became very enthusiastic about the expediency of the procedure. As the technique had never been properly reported and published, I was asked to do this and to analyze the results. I know that a pharyngeal flap elongated via the normal approach, which you refer to Tessier, is the proper solution to many anterior palatal defects. However, in some cases of wide defects in patients who had used obturators since childhood, it may be necessary to provide a large amount of tissue, and the technique of Johanson of using a pharyngotomy is indicated. The plastic surgeon should not be deterred from using this approach as the method in an ingenious way provides exposure of the pharynx. The pharyngeal flap can be extended under full vision to the esophageal borderline; this is impossible from the mouth. Furthermore the donor area can be closed, and the extremely long flap will reach the alveolus without undue tension and risk of circulatory distress.

In short I think that the technique of Johanson deserves recognition as an important innovation of the pharyngeal flap method.