Drs. Shelton and McCauley describe how a patient, KD, received a hinged prosthesis and her experiences in adjusting to and learning to use the appliance. I join them in giving Dr. Mitchell credit for what he did in an earlier era.

Early in my experience as a prosthodontist, I made several hinged prostheses. They are more difficult to construct than are fixed prostheses. It is difficult to record or make an impression of the nasopharyngeal region by use of impression materials during function when the velar section of a prosthesis is hinged and unstable. I am not surprised that openings existed between the pharyngeal walls and the hinge region of the prosthesis. Modern fixed prostheses, if properly designed and fabricated, have less effect on dentition than that apparently experienced by KD. The nasal extension to the pharyngeal section to substitute for the vomer has no value and is no longer used.

Hinged appliances are also more difficult for patients to use. The movement of the velar section of a hinged prosthesis depends upon constriction and elevation of the remnant of the soft palate. By constriction and elevation, the halves of the cleft soft palate move medially and elevate the hinged section of the prosthesis. In contrast, closure of the velopharyngeal port by a patient wearing a fixed prosthesis requires that the pharyngeal walls close against the velar segment of the prosthesis. No portion of the prosthesis need be moved; oral direction of air flow for speech is a relatively simple matter.

Most of the patients for whom I constructed hinged prostheses did not develop good speech, and it was an ordeal for them to attempt to do so. KD was exemplary in the perseverance with which she learned to use her appliance and to speak intelligibly. Muscle strengthening may have contributed to her success, but she had to learn to move the velar section to use the prosthesis successfully.

Compensatory movements are developed by many patients who wear palatal prostheses. For example, patients who have lost portions of the velum because of malignancy develop excellent movement of the posterior and lateral pharyngeal walls in a short period of time. They may also learn to use the tongue to block openings into the nose, and if the uvula is present it may become hyperactive. These compensations contribute to the development of intelligible speech.

In summary, the case report is interesting historically and relative to the development of skilled velopharyngeal movements. I would not recommend a hinge-type prosthesis for any patient. Today’s prosthodontists are able to construct prostheses that are more effective in the improvement of speech and that have less effect upon dentition.

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