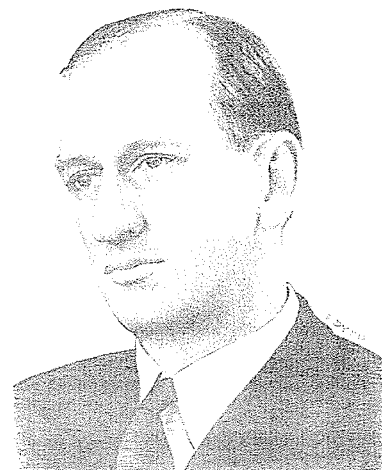


27. Oral Mucoperiosteal Flap Transpositions for Palate Lengthening

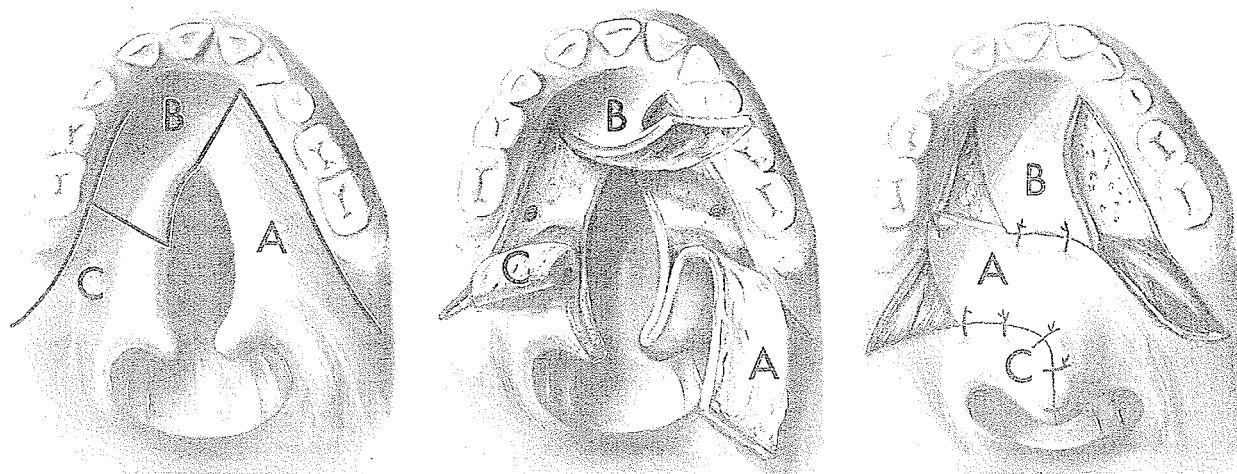
CUTHBERT

UNOBTRUSIVE, quiet James Cuthbert came to plastic surgery as an orthopedic registrar during World War II. He joined Gillies at Rookdown House, soon learned about pedicles and cut a lot of flaps for war wound defects, especially for the hand. After the war he was invited to Yugoslavia to establish a plastic surgery service there. Several days after I arrived to study with Gillies in 1948, a farewell party was given for Cuthbert, who was leaving for a new position in South Africa. Gillies, in an after-dinner speech, predicted that Cuthbert would take plastic surgery to Africa and "turn up all the giraffes' noses."

By 1951, James Cuthbert, then of the University of the Witwatersrand, Johannesburg, had designed a multiple transposition



James Cuthbert



of oral mucoperiosteal flaps to achieve greater posterior displacement of the palate, minimize the risk of fistulae and avoid a straight-line contracture along a two-layer closure. He designed the main flap A which, when cut and peeled back, exposed the posterior palatine vessels; these were then ligated and divided. A shorter flap C was dissected and elevated, and the vessels were divided. Flap B was left, based anteriorly, and it too was elevated on the vessels coming through the incisive foramen. The nasal mucosa was mobilized and divided transversely to allow posterior displacement of the soft palate. Flap C moved back with the soft palate, flap A was transposed at a 90-degree angle and flap B slid toward the midline to close any anterior hard palate cleft.

When the cleft extended through the alveolus, an anterior first-stage, Veau-type closure was achieved and the transposed retropositioning carried out a few months later.

The lining layer on the nasal side was closed as well as possible. Cuthbert rationalized:

If the transverse relaxing incisions leave a midline deficiency, this is of no importance as long as it is placed to lie under the primary transposed flap A which will prevent fistula formation.

Gillies was intrigued when Cuthbert's method came out in the *British Journal of Plastic Surgery*. By now I had returned to England to write the book with Gillies and remember how impressed I was with Sir Harold's open-mindedness. He was always willing to try a reasonable design even by one of his previous students. He used the multiple transposition flaps on a few palates but without dramatic results. We were all disturbed by the large raw nasal area.

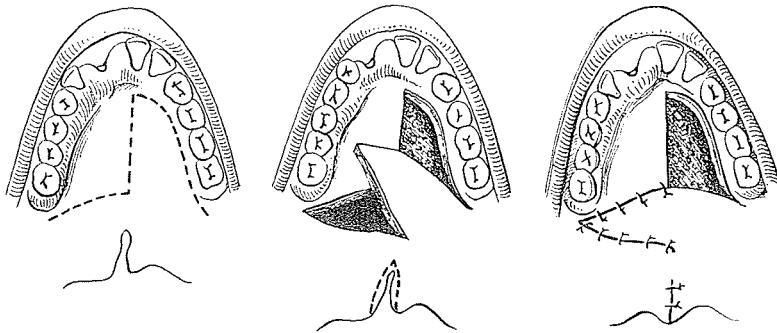
The last time I saw Cuthbert was during the 1959 International Congress in London. He, Barbara and I had been invited to a delightful cold buffet by Lady Sam at the Gillies' flat on Queen Anne Street. After a few drinks and some fresh salmon from Scotland, Sir Harold and Cuthbert had great fun pantomiming the casting, hooking and reeling in of the great fish from the waters of the South African shoreline. Five years later, after a lengthy illness with severe residual pain, Cuthbert ended his life.

GIBSON

Thomas Gibson of Canniesburn Hospital, Glasgow, Scotland, had made several basic contributions to plastic surgery including the important treatise on the characteristics of cartilage. Then in 1959, 10 years before he became the respected editor of the *British Journal of Plastic Surgery*, he described a triangular flap for lengthening the short secondary palate which was similar to the Cuthbert principle. He reported no contracture of this flap with the nasal side raw, but combined the procedure with a Hynes pharyngoplasty.



Thomas Gibson



He summarized that it was simple, was completed in one stage with a posterior displacement of 1.5 to 3.0 cm. and had no tendency to contract; any anterior holes could be closed with an obturator. In 1967 Hynes, after Gibson admitted using his pharyngoplasty, endorsed the Cuthbert-Gibson transposition flap for lengthening.

In 1976 Gibson wrote:

The transposition flap for lengthening the palate is an excellent operation with only one drawback. It is not always easy to avoid fistulas in the hard palate, particularly when the bony cleft is inadvertently exposed.

