Commentaries about the Papers of Dr. Pruzansky and Dr. Schultz

I. The brief, in dissent of use of early orthopedic devises, points out some of the questions that need to be answered by those individuals investigating this method. It is planned that answers to these and other questions may be forthcoming in carefully controlled experimental studies, comparing pre-surgical orthopedics with standard surgical methods.

JOHN H. FISHER, M.D.

II. After reading the 'brief' challenge against pre-surgical orthopedics and bone grafting given by Dr. Pruzansky as the discussor of the bone graft panel at the 1963 Cleft Palate Meeting, we have been permitted to print a reply. We wish to thank the editors of the *Cleft Palate Journal* for this courtesy.

In the first paragraph of this brief challenge the statement is made: 'what has been offered is a costly manipulation and a surgery that is needless and sometimes barbaric'.

What Dr. Pruzansky seems to be indicating is that we don't need progress in cleft lip and palate surgery—that we have 100% perfect results now. Is there any plastic surgeon who would agree with this? It is understandable that an orthodontist would find every conceivable fault with any procedure which might reduce the need for orthodontia in the future; however, personal reaction should not blind the need for continued investigation. We are not aware of any mortal man who has the ability to judge or predict cause and effect in medicine without trial. In his own 'brief', in paragraph 38, Dr. Pruzansky admits that review of his series of patients revealed that 63% had some degree of dental malocclusion and 40% had complete buccal crossbite. Apparently he is content to accept this? Do we discard our preventative vaccines and direct all our attention to only the treatment of active polio, diphtheria, typhoid fever, etc? Can we also prevent dental malocclusion, or will we stop short of finding out?

We agree with the concept of muscle moulding, and it is difficult to understand why Dr. Pruzansky details this process so minutely as an argument against 'pre-surgical orthopedics and bone grafting'. Without muscular moulding, maxillary bone grafting and even orthodontia would suffer. Also, would Dr. Pruzansky list the muscular attachments of the vomer to which he refers? We know of none.

Again in paragraph 39 the statement is reiterated: 'the malocclusion in the child can be readily, quickly, and less expensively treated by simple expansion procedures'. We doubt that this is the proper use of the word

readily, since there are far too few orthodontic facilities available for even the affluent patient, not to mention the clinic case; we disagree with the use of the word *quickly*, knowing of usual prolonged and expected orthodontic care; and we question, to the highest degree, the use of the terms *less expensively* in that statement.

To agree with Dr. Pruzansky's 'brief challenge', most orthodontic treatment would have to cease in patients with intact normal maxillae, for he states: 'To immobilize the premaxilla or other segments by a bone graft prohibits manipulation of these segments at a later date'. Nonclefted intact bony maxillae have been changed by orthodontia for many years. Clefted and bone-grafted maxillae in our clinic have both been moulded with ease. Experience is as usual: more reliable than opinion and prognostication.

Dr. Pruzansky has continually urged us to maintain the status quo, to leave well enough alone. But in spite of his opinion, there are those of us who see in lip and palate patients the following problems: feeding problems, psychological problems in new parents with cleft lip babies, irregular dental structures, collapsed maxillary arches, oronasal fistulae, depressed nasal floors, missing teeth, teeth erupting into cleft spaces, asymmetrical lips because of asymmetry of underlying bone, poor speech, nasal deformities, protuding and unstable premaxillae, and poor cleft lip results and poor cleft palate results with psychological and functional cripples.

We are not, and should not be satisfied.

In his 'brief discussion', constructive criticism is lacking in how to determine which way to decide when and where to do pre-surgical orthopedics and bone grafting. Rather, the impression is given that this is all bad, and that no good can be derived from such investigation. This is not so. There are those of us who believe that the proper place will be found, through continued work, for this technique, and that in the future, pre-surgical orthopedics and bone grafting will assume a normally important position in the rehabilitation of cleft lip and palate patients.

Almost 20 years experience by competent orthodontists and surgeons in Germany have demonstrated well the effectiveness of bone graft in the rehabilitation of the cleft palate patient. Although well-controlled studies do not extend over as long a period, *expert* clinical opinion by many men, who are well trained in all facets of the problem, does give satisfactory emphasis to the need to continue this approach.

The loud cries of an aged philosophy are falling on enlightened ears, and in spite of the noise, true values alone will be recognized.

Charles E. Horton, M.D.
Hugh H. Crawford, M.D.
Jerome E. Adamson, M.D.

III. The sequellae of a complete palatal cleft have, in the past, more or less been accepted by the surgeon and his patient. The orthodontist with

an attitude of 'wait for the permanent dentition' had little to offer. With continued pressure by the plastic surgeon for earlier intervention, some orthodontists recently have produced startling results at the four year old level. However, all of this was still corrective therapy: the deformity had already occurred. Why not control the movement of the maxillary segments following the lip repair so that they do not collapse into a cross bite? Preventive therapy has always been one of medicine's mainstays, and this is the aim of McNeil, Burston, and others.

We are well aware of the moulding action of the re-established musculature across the cleft. Its dynamic forces are so powerful and act so quickly that retrusion and collapse can occur in a few short weeks, when nothing is done to prevent it. We propose to use these forces to direct the movement of the maxillary segments and create a harmonious arch which properly relates with the mandible. Is it so terrible that we should want to prevent rather than correct?

Retrospositioning of the premaxilla by elastic forces before the lip surgery is helpful to the surgeon and means less scar for the patient. The illustrations used by Pruzansky are not characteristic of the patients we see. Collapse is commonplace.

The fact that the arch can be correctly aligned before the dentition has erupted is shown by Figures 11, 19, and 28 in our previous paper (Brauer, R. O., and Cronin, T. D., Maxillary orthopedics and interior palate repair with bone grafting. *Cleft Palate J.*, *1*, 31–42, 1964). It may be true that we are doing this in certain patients where it is not necessary. Experience and time will show us where we are wrong. To compare this work to that of Brophy is to fail to understand our philosophy and technics. Dr. Pruzansky has pointed up the danger of surgery per se when used for the early patient, but embraced it for the secondary or older patient. The dangers are still present, regardless of the age. If bone graft is necessary to control the corrected arch of the older patient, why would it not be just as good, if not better, to do this at six months?

The thousands of cleft patients of the present and past speak all too eloquently of the need for a new and continuing approach. We are tired of 'going it alone'. We want the continued interest and active support of the orthodontist. To ridicule and snipe at us is not healthy. We are not orthodontists by interest, only by default.

RAYMOND O. BRAUER, M.D.