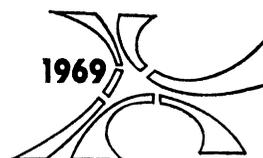


## Presidential Address: 1969



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I am a little in awe as I look over this sea of bright and shining faces. Never before has a President of this American Cleft Palate Association had the honor of speaking to such a large Luncheon assemblage. I am reminded of the politician who, arising to address a crowd of potential voters, began his greetings by stating how pleased he was to see such a dense crowd. At this point there came a voice from the back of the room, "Don't be too pleased, we ain't all dense".

Seriously, it is indeed an honor to be selected as President of the American Cleft Palate Association and, in this capacity, to work with the many dedicated persons, who, coming from different professions, various universities, and numerous centers, have made this Association the splendid interdisciplinary organization into which it has grown. And now to its other labels, we must add the title *International*. Just as no single profession or discipline can hope to have all the answers, so no one country or nation has a monopoly on either the answers or the cleft problems which still require answers. I believe it was Goethe who stated, "Science and Art belong to the whole world and before them vanish the barriers of nationality". How true it is today! The American Cleft Palate Association is delighted and honored that so many of you, our friends from other lands, have seen fit to travel long distances, frequently at considerable inconvenience and difficulty, that you might come and share with this Congress your knowledge, your facts, your experience, your wisdom.

To many of you, this interdisciplinary approach may be a new learning situation. For a dentist to listen to the speech therapist and for both, in turn, to listen and learn from the surgeon, and for all three to turn to the expert in the behavioral sciences, may really be a unique, and perhaps, iconoclastic experience.

I think that a brief look backwards at the earliest beginnings of this organization is sufficient to bring into perspective the many, many

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changes which have occurred in the care of the cleft palate child in the last three decades. You perhaps have noted from your printed program that this Congress coincides with the 27th Annual Meeting of this society. I would point out that even the name, American Cleft Palate Association, has been arrived at by a devious route. In March, 1943, the Dental Division of the Pennsylvania State Department of Health offered a short course to acquaint dentists with obturator construction and with medical, dental, and speech problems of cleft palate patients. At this first meeting, there were some 25 dentists in attendance and this meeting was conducted by the late Dr. Cloyd Harkins and by Dr. Herbert Koepp-Baker. During one of the discussions, it was suggested that a permanent organization and some form of perpetuity be established. Therefore, at a meeting in Harrisburg in April of '43, the American Academy of Cleft Palate Prosthesis was formed with the following stated objectives: "Promotion of the science of the rehabilitation of the cleft palate cripple; to promote cooperation among other specialties of the healing arts group; and stimulation of lay groups". The fledgling organization grew. Some eight years later, in 1951, a new constitution was adopted which provided a broader-based membership open to doctorates in other fields and at that time the name of the organization was changed to the American Association for Cleft Palate Rehabilitation. While the cleft individual was still frequently being rehabilitated with a prosthesis, this was no longer the main emphasis or the major area of patient care. Membership in the association increased steadily and the organization subsequently underwent still another change in 1962 to its present title, The American Cleft Palate Association.

Knowledge is a wonderful thing, but as Emerson stated, knowledge exists to be imparted. Toward this end, the American Cleft Palate Association and its predecessors have, by its publications, made a considerable impact upon the treatment of clefts throughout the world. In April, 1950, formal publications began with a single issue of a mimeographed *Bulletin* under the editorship of Herbert Koepp-Baker. In January, 1951, a quarterly *Newsletter* with Eugene McDonald as Editor was begun. This *Newsletter* changed format and ultimately became the *Cleft Palate Bulletin* in 1954. Successive Editors were Robert Harding, Dan Subtelny, Ernest Hixon, Galen Quinn. Finally, this *Bulletin*, in turn, gave birth to the current periodical, the *Cleft Palate Journal*, whose first issue was in January, 1964. I think it would be appropriate at this time, acting as the President of this Association, to pay tribute to the men and women who have worked so diligently to make of this publication the meaningful one it has become. I would particularly take this opportunity to commend, and ask you to also, Dr. Hughlett Morris, who has been most active in the creation and development of our current *Journal*, and whose term, unfortunately, will expire next spring.

I don't know how many of you watch TV, but the comedian, the master of ceremony, and the wit, makes a special point of personalizing his presentation by making himself a part of his story. He will frequently start off by saying, "When I was a little boy", or, "You know, a funny thing happened to me on my way to the studio". Please don't think me too corny if I follow the same line. To make this story personal, just supposin' if I had been born with a cleft lip and a cleft palate. I suppose, for correctness' sake, since this is the American Cleft Palate Association Luncheon, I should say cleft of the primary and secondary palate instead of using the looser generic term of cleft lip or hare lip. Well, what then might have been my fate? First off, I would probably have been born at home, and as a matter of fact, I was. The usual, rotund, cigar-smoking, country doctor was in attendance, but I seriously doubt that he knew very much about this particular, peculiar-looking entity that we now label cleft lip and palate. Forty-five years ago, there were very few pediatricians and there were no such persons as plastic surgeons as we know them today. In fact, there were very few physicians who confined their practice to surgery. The same doctor who delivered me not only could set a broken bone or lance a boil, but in addition to delivering babies and taking care of scarlet fever and grandma's quinsy, he also did appendectomies, herniorrhaphies, and took out an occasional gallbladder. He probably would have not seen a cleft lip before, or if he had, it might have been part of a wizened embryo in a bottle of alcohol where he had gone to medical school. Oh, undoubtedly, he would have looked this up in a text book somewhere, and not above doing his own surgery, proceeded in cookbook fashion to work on my lip and/or palate.

But supposin' if my mother, who is a very strong-willed character, would have asked him, "Doctor, how many of these have you seen before, or how many of these have you operated on before", and the answer wasn't very convincing, and supposin' that she had said, "Well, let's take this baby and take him to the big city hospital, where somebody certainly has seen this sort of thing before and where the best of care can be obtained"; what then, would have been my fate? I undoubtedly would have gone to one of the large metropolitan general hospitals, for this preceded the establishment of a hospital specializing in children's care alone. I would have had my hare lip repaired by a general surgeon, who probably would have been familiar with the works of Rose and Thompson or the Blair modification of the Mirault operation. While there were some ingenious flap procedures, Koenig and Hagedorn and Owens and the like, these were not in wide usage. My lip, most likely, would have been repaired by a straight line closure, perhaps with a considerable amount of tension with stay sutures just to hold the lip together while it was to heal. The great triumph was keeping the lip together and little matter that the stay sutures might ultimately result in disfiguring cat whisker-like scars (9, 12).

In those days, and certainly for several decades thereafter, no one paid much attention to the little white ridge that lies between the red portion of the lip and the skin, the structure we now call the mucocutaneous ridge, nor did anyone pay much attention to the little peaks in this line, the cupid's bow. There would have been little concern with the nostril floor or the alar cartilages or the apex of the nostril, for after all, the defect was in the lip (9).

Now supposin' if my family had insisted and we had gone to whatever portion of the world where the care and knowledge about clefts was then considered the greatest. This might well have been Philadelphia or Baltimore or New York. There it would perhaps have been noted that this poor cleft child had been feeding poorly at home and a pediatrician brought in on consultation, for the cleft child had to be "built up" preoperatively (6). To achieve this, the pediatrician might have recommended feeding with a rubber tipped glass syringe. In addition to boiled milk, orange juice with cane sugar was given twice daily, and in many instances, sodium bicarbonate in proper dosage, three times a day, as it was thought that this tended to lessen acidosis after operation (7). Dr. J. A. Henske (6), a pediatrician from Omaha, recommended early hospitalization since he felt it was a rare mother who could handle these cleft children at home. He used quartz lamp exposure during the daily bath, and advocated feeding the cleft babies lying absolutely flat on their backs. If the babies insisted on spitting up or regurgitating, the head of the bed might be elevated 6 inches. If they still persisted, then they would have to be fed by gavage feeding. The choice of foods was considered very important. Incidentally, a Dr. Schultz from Milwaukee favored such delightful mixtures as lactic acid and Bulgarian buttermilk (11). All of the infants who were admitted to the hospital in this era, had their chests x-rayed to see if they had an enlarged thymus, and if such was diagnosed, the baby received two radiation treatments, three to seven days apart, in order to reduce the size of the thymus, for everyone knew that this thymus condition produced respiratory problems postoperatively (6, 7). Dr. Edward Kitlowski, writing in *Annals of Surgery* in 1928 (7), wrote knowingly of giving daily exposures to ultraviolet ray as a preoperative preparation, for it was felt to have a beneficial effect upon hemoglobin. He noted in his writings that there was a pronounced tendency to respiratory diseases in congenital clefts of the lip and palate, which he attributed to the inrushing of air that has not been warmed and cleansed properly by the normal passage through the nose. To help correct this abnormal situation, 2 drops of 20% Argyrol were placed in each nostril 3 times a day while the poor little patient was waiting for his surgery and getting his daily exposure to the sun lamp, dutifully swallowing his sodium bicarbonate, and getting his thymus radiated. Across the Atlantic, Mr. O. L. Addison at the Hospital for

Sick Children, Great Ormund Street, writing in *Lancet* (1) in 1925, declaiming along similar lines, emphasized preoperative prophylactic care. He felt that malnutrition lowered resistance to infection and that unhealthy gums must be made healthy preoperatively by swabbing them 3 times daily with a weak solution of citric acid. Mr. Addison went on to aver that the tonsils, whether visibly infected or not, must be enucleated and the adenoids, if present, removed. This tonsilloadenoidectomy should be done at least 4 weeks before any palatal surgery. If the lip repair had proceeded on schedule, the resultant suture line was then painted with  $\frac{1}{3}$  strength iodine. The palate, after its surgery, was painted with 20% Argyrol, along both the suture lines and the lateral incision.

Many surgeons agreed with Dr. Warren B. Davis (5), who noted that he treated the wide alveolar cleft by dividing the outer portion of the alveolar process lateral to the canine fossa with a thin chisel and then fracturing this in a green-stick manner and wiring it to its medical side to hold it in position. Chloroform or drop ether would have been the anesthetic agent. Postoperatively, dextrose feedings were given intravenously or intraperitoneally to combat dehydration. After the surgery, it was not uncommon to have a proctoclysis with solutions administered per rectum (5, 6).

Well, what were the results of this, my vicarious surgery? Published mortality figures from surgery ranged from 2% to 7% (1, 2, 6, 7, 10). Surgical failures in palate repairs ranged between 30 and 40% with the rare statistical evaluation including comments like, "No union, small hole, large hole, and good closure" (10). What the speech results were like, even in "good closure", was not revealed. Dr. Albert Davis of San Francisco, writing in *Surgery, Gynecology, and Obstetrics*, in 1931, wrote: "The great number of operative failures in surgical treatment of cleft palate is estimated at 70-80%. Many prominent surgeons have abandoned palatoplastic procedures because of the preponderance of such failures" (10).

Little wonder that cleft palate rehabilitation was so frequently centered around a prosthetic speech-aid and that there was a great need for an organization like the American Academy of Cleft Palate Prosthesis.

Not everyone agreed with Dr. Davis about abandoning surgery. Many schemes were proposed to improve the surgeons' batting average. In 1927, Dr. Sterling Bunnell (3) devised a silver cage, like a small catcher's mask, to keep the offending tongue away from the suture line of the repaired palate. Even more ingenious was the method devised by Dr. C. Ulysses Moore (8) of Portland, Oregon, who felt that the preoperative cleft palate care of the child was very important. Any method that lessened the postoperative use of the lips and jaws, he felt, hastened healing and decreased the number of operations. He literally put them in training. He wrote, "An infant will forget that he has a mouth, pro-

vided that nothing is permitted to touch his lips for a period varying with his age. From one to three weeks of preoperative training usually suffices. The hands must be tied down and feeding done with a small catheter, preferably through the nose. In due time, the lips remain almost as quiet as the ears" (8).

Ladies and gentlemen, some of this may sound ludicrous, but this is within my lifetime and within the lifetime of many of you, so before we laugh at or scorn our predecessors' mistakes, let us pause and consider what Priestly so aptly pointed out, "The wisdom of one generation will be folly in the next". At the 10th International Cleft Congress in the year 2005, will the assembled interplanetary Congress members be reading and chuckling about what we here in Houston this week are proclaiming as truths? We have been seeing and hearing of some ingenious and successful modes of therapy as well as in the overall field of basic science research. We have heard little or nothing of our failures.

Who was it who said, "We learn wisdom from failure much more than from success. . . . We often discover what will do by finding out what will not do, and probably, he who never made a mistake, never made a discovery".

All good intellects have reported since Bacon's time that there can be no real knowledge but that which is based on observed facts, for what is all knowledge but recorded experience, an accumulation of small facts made by successive generations of men. As Oliver Wendell Holmes stated, "Wisdom is the abstract of the past". Admittedly, our professional knowledge advances by slow and sometimes feeble steps. While this may be frustrating, is it not a surer path? We must carefully document, patiently record, and then even more judiciously evaluate all of our scientific experiences. It is the close observation of little things which is the secret of success, the little bits of knowledge and experience carefully treasured up, growing at length into a mighty pyramid. However, we must be careful that this structure, this pyramid of knowledge, be built well, for it is only as good as the individual building blocks which go into it. Of greater importance, perhaps, is how we view the knowledge we already have accumulated.

In closing, might I quote from Charles Darwin, who wrote in his *Descent of Man*, "False facts are highly injurious to the progress of science for they often endure long. But false views, if supported by some evidence, do little harm, for everyone takes a salutary pleasure in proving their falseness and, when this is done, one path toward error is closed and the road to truth is often at the same time opened". I suppose that what I'm trying to point out is that while we've heard and learned a great deal here this week in Houston, some of the things we now may hold dearest and truest will be considered folly by the next generation. Perhaps I should paraphrase the politician's heckler I quoted earlier, "Don't be too smug, we ain't all that smart". Perhaps, it was better

stated thusly: "Knowledge is proud that he has learned so much. Wisdom is humble that he knows no more".

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