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بالرسالة صفحات
لم ترد بالأصل

STUDY OF SURGICAL REPAIR OF PALATAL FISTULA AFTER CLEFT PALATE REPAIR

THESIS

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In

General Surgery

By

Mohamed Helmy Al-Tabakh
(M. B., B. Ch. Tanta)

Supervisors

Prof. Dr.
El-Sayed Mandour Ismail
Prof. of Plastic Surgery
Faculty of Medicine
Tanta University

Prof. Dr.
Helmy Hamad Ahmed Shalaby
Prof. of Plastic Surgery
Faculty of Medicine
Tanta University

Dr.
El-Sayed M. Abdel-Razek
Lecturer of Plastic Surgery
Faculty of Medicine
Tanta University

FACULTY OF MEDICINE
TANTA UNIVERSITY
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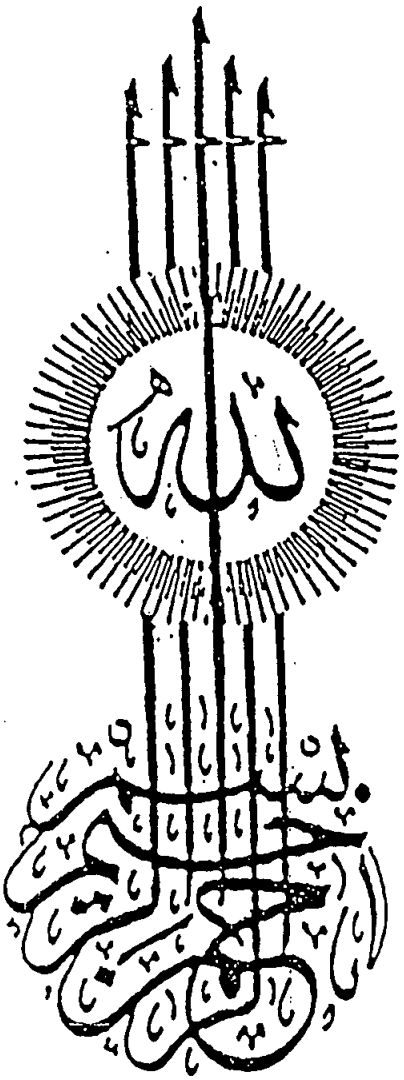

قالوا سبحانك

لا علم لنا إلا ما علمتنا
إنك أنت العليم الحكيم

صدق الله العظيم

(البقرة ٣٢)

To My Family

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INTRODUCTION

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Palatal fistula repair is one of the most challenging problems to a plastic surgeon. It is one of the examples where a minor surgical defect requires a big operative procedure to close it (Randall, 1979)[1].

Palatal fistula could be very annoying for the patient, by the troublesome symptoms it produces, and the surgeon, by the difficulty encountered in its repair. These difficulties were summarised by Hirshowitz et al., (1970)[2] as: The unyielding relatively immobile mucous membrane of the hard palate and the short nasal mucous membrane.

Cleft palate repair carries a significant but acceptable risk of fistula formation where the strongest predictor of the occurance of a palatal fistula is the surgeon performing the procedure (Emory et al., 1997)[3].

Fistula formation is related mostly to the experience of the operating surgeon (Emory et al., 1997)[3]. Other related factors include the type of repair (Amaratunga, 1988)[4], the extent of clefting (Cohen et al., 1991)[5] and the presence of upper respiratory infection at the time of repair (Musgrave et al., 1960)[6].

The reported incidence of this problem varies widely from 0 to 63 percent and recurrence after repair is common (Cohen et al., 1991)[5].

Hinge flaps (Riatala, 1971)[7], do not suite anteriorly placed fistulae as the mucous membrane of the anterior palate is very thin, easily torn, difficult to mobilise and difficult to fix. Mucobuccinator flaps (Hirshowitz et al., 1970)[2], used for closure of anterior palatal fistula do not suite cases of cleft palate without a gap in the alveolar arch. Tongue flap (Pigott et al., 1984)[8], used for closure of palatal fistula as a staged operation has a high morbidity, needs a cooperative patient and is not without complications. Tadpole flap based on Millard island flap provides in most cases a one layered repair instead of two layers (Henderson, 1982)[9] . The nasolabial flap introduced by Wallace (1966) [10] for repair of palatal fistula brings foreign tissues to the area. The supraalveolar nasal approach is used to achieve double layer closure of palatal fistula (Mostafa et al., 1991)[11].

REVIEW OF LITERATURE

REVIEW OF LITERATURE

PALATAL FISTULAE

Oronasal fistulae are troublesome complications occuring oftenly after cleft palate repair (Amaratunga , 1988)[4] .

Randall (1986)[1] emphasized the difficulty in achieving an intact palate after a fistula had occured.

Primary closure of cleft palate should result in an intact palate with separation of the oral and nasal cavities. The occurance of secondary fistulas in the palate along the site of the original closure represents a failure of surgical repair.

The incidence of recurrent palatal fistulas following initial fistula repair is thirty seven percent.

Recurrence of cleft palate fistulas was not influenced by severity of cleft or type of original palate repair. In the same study, second cleft palate fistula recurrence occured in twenty five percent of patients (Cohen et al., 1991)[5] .

Rintala (1980)[12], reported treatment of 88 patients with palatal fistulas. Anatomic and/or physiologic closure was achieved in 88 percent of patients. Minor recurrences causing some, but not significant trouble were noted in 11 patients (13 percent). Major recurrences were found in only 3 patient (4 percent).

Amaratunga (1988)[4] found that closure of cleft palate fistula was totally successful in 56 percent of 73 patients and partially so in 34 percent.