

THE SANCTITY OF PUTTING PACKS AFTER PALATE RETROPOSITIONING

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SUMMARY

The validity of the concept of packing lateral raw areas following retropositioning surgery, for cleft palate, is questioned. Authors believe that it is a serious misconception to presume that packing can help in haemostasis, easing suture line tension and that it prevents food particles from going under the mucoperiosteal flaps. A case has been made for leaving these raw areas open as it leads to rapid epithelialisation, shorter hospitalisation and it eliminates foul mouth odour post-operatively. Our experience on 42 consecutive patients makes us condemn this concept.

Key Words : Cleft Palate, Palato Plasty.

When concepts get established it is a mammoth task to change them! The dictum percolates down through generations of successive trainees, unchallenged ; for each technician has been groomed in the philosophy of his teacher. Such is the case under current consideration where we question the necessity of packing palatal raw areas after retropositioning surgery.

This question is of particular relevance in the Indian context where we are still religiously taught to pack lateral raw areas after palate retropositioning when a majority of surgeons across the world have opined to the contrary for last several decades (Stark, 1964, Watson, 1980, Randall, 1984). It was with this background that we took upon us to investigate if the Indian tropical environment or the patient material made it any different for us to be still pursuing the art of packing, which the authors have now come to realise as an archaic concept.

Material and Methods

This concept of not packing the palatal raw areas was employed in 42 consecutive retropositioning operations for cleft palate between October 1988 and April 1990. The patient's age varied from 1¼ years to 16 years. Their distribution according to Davies and Ritchie classification (1922) for such defects indicated that 17 patients belonged to group II, 15 were in group III

unilateral and 10 patients were of group III bilateral type.

Preoperative assessment of these patients included a haemogram, bleeding and clotting time, urine analysis and a throat swab for culture and sensitivity. The patients were operated evenly between the summer and winter months.

Palate retropositioning was carried out by the standard two flap technique. Intravelar veloplasty was routinely done in all the patients. The palatal mucoperiosteal flaps were fixed to the hard palate or the nasal lining without any bolster stitches. The lateral raw areas following retropositioning were left as such and not packed with any material in any of the patients, except one.

Some patients could not get a throat swab culture evaluation in time preoperatively and only these patients were given crystalline penicillin, starting a day prior to surgery and continuing for 4-5 days post-operatively. Post-operatively patients were given mouth washes after every feed.

Results

All patients, without any exception, had rapid epithelialisation of the lateral raw areas. On the 7th or 8th day the whole palatal surface appeared completely healed and consequently around this time they were started on a soft diet. Also, remarkably, all patients were free of foul mouth odour following surgery.

In one patient, a 3 year old boy, continuing brisk ooze during the surgery compelled us to lightly pack the lateral raw areas with saline soaked ribbon gauze to achieve some haemostasis, if possible. The pack was removed the following morning. The patient was transfused a unit of blood in the post-operative period and was the only patient in the series to have received it. Although his pre-operative investigations were reported to be normal, the child was referred to haematologists subsequently who informed us of an abnormality in his clotting mechanism. Besides this two other patients had minimal ooze from the cut edge of the mucoperiosteal flaps for a couple of hours, which settled conservatively.

Although not studied objectively, it is a positive feeling of all in our unit that the hospitalisation period of these patients was less as compared to those patients before this study who had packs placed in lateral raw areas.

Discussion and Conclusions

A couple of decades back there were clearly two schools of thought, 'Packers' and 'Non-Packer's. The "Packers" included in their list of advantages haemostasis, easing of tension on the suture line and preventing food material from going under the palatal flaps (Broomhead, 1986). 'Non-Packers' philosophised it as an unnecessary step. However, none put forward his views objectively in the form of study, presumably regarding it as a trivial affair dependent more on individual surgeon's fads. With the current study we propose to initiate a group of 'Converts', from 'Packers' to 'Non Packers', and would clearly and categorically condemn its usage.

Perhaps two great stalwarts who were ardent advocates of packing and who influenced the majority of British, East European and also Indian thinking were E.W. Peet (1969) and F. Burian (1967). Both advised on using iodoform soaked gauze packs with Burian also insisting on anchoring it to the teeth with a stitch. A controversy was raging even then, for Stark (1964) had advised on not packing the raw areas. Now while the 'Wild West' seems to have formed a

consensus of opinion against packing (personal observation) we still seem to be assiduously following that principle.

We don't agree with the concept of packing for the following reasons :

1. Packing cannot appreciably contribute to providing haemostasis. Bleeding from flap edge or underneath can be easily and precisely controlled by bipolar cautery. Palatal bone stripped of its periosteum does not continue to bleed. Moreover packs can only achieve haemostasis if they are packed firmly into a cavity with some pressure being maintained. Such a state of affair does not occur following palatal surgery.
2. Packing is generally done with ribbon gauze soaked in Tincture Benzoin Co. This flexible material can in no way provide support to the thick muco-periosteal flaps. Tension can only be reduced by adequate flap mobilisation (Trer, 1984). When even hamulus fracture is considered an unnecessary step in easing tension, by some surgeons, how can packing with flexible material contribute to relaxation at the suture line? So much so, Jackson (1987) even advocates closing of the lateral raw areas, relying on visco-elastic properties of the mucosa.
3. Whether the area is packed or not, patients are kept on a fluid diet for a few days post-operatively. Thus, ribbon gauze packs being fluid permeable cannot prevent fluids from going under the flaps. The fear that this would affect healing is thus unfounded.
4. Patients with packing uniformly have foul odour from their mouth.
5. Infection can brew in the post-operative period as a result of packing, leading to pyrexia. It is advocated if fever ensues the packs should be removed (Sharma & Chandra, 1976, Broomhead, 1986)!
6. At the time of pack removal there is bleeding from the raw area and damage to neo-epithelium.
7. Raw areas epithelialise early without packing

- and there is early resumption of normal diet.
8. Palate surgery is now being done at 3-6 months age at many centres. Packing raw areas in such young infants can be dangerous as any dislodged pack can easily be inhaled, leading to death (Sanders, 1987).
 9. It is our unit's observation that patients without packs have at least 5-6 days shorter hospitalisation period.
 10. Since packing is an unnecessary step, not indulging in it saves operative time !!

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