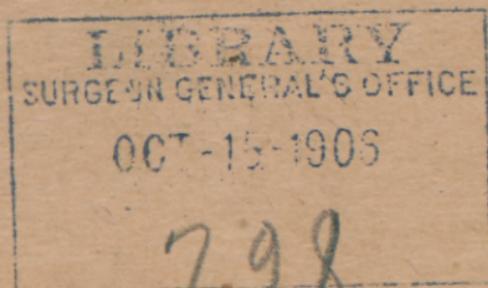


SHANDS (A.R.)

Case of hare lip + + +



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CASE OF HARELIP COMPLICATED WITH INTERMAXILLARY FISSURE.

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Frank Bell, Age 12. *Diagnosis:* Single harelip with fissure of superior maxillary bone at right intermaxillary junction. Admitted to the Orthopædic Service at Emergency Hospital and Central Dispensary, Dec. 5th, 1896.

In presenting this case, it is not intended to describe the etiology of harelip, but simply to call attention to several peculiar features in this case and to describe the operation performed. Photograph No. 1 shows quite well the depth of the bony fissure which is bounded by the first molar on the right and by right central incisor on the left, extending to junction of the superior maxilla with palate and nasal bones in shape of an inverted "Λ"; depth of fissure being about one inch. The result of this non-intermaxillary union was that the alveolar arch grew upwards at an angle of about forty-five degrees from the first left bi-

cuspid, pressing the nose to the left, which is well shown in photographs 1 and 2.

The right bicuspid was absent and the central incisors poorly developed. The central incisors fail to approximate with their fellows of inferior maxilla by about one inch, and one-half inch respectively. It should be mentioned that there was no cleft palate.

This bony prominence with the right central incisor extending into the nostril prevented the approximation of the fragments of the lip in a satisfactory position; hence it was decided to move this obstacle by sawing it off, which was done by first dissecting back the gum tissue covering it, then making an incision with a saw from the left canine obliquely across to the apex of the "Λ" fissure already described. The incised bony surface was then covered with flaps of the gum tissue previously dissected back.

Thus the first part of the operation being completed, the next step was the approximation of the fragments of the lip. To avoid tension as much as possible, and to get best apposition, the labial connection with maxilla was freed well up under the cheek and back to the angles of the mouth. The right flap was pared from the apex of the cleft along its entire vertical length, and for about one-half inch on its horizontal surface, cutting away about one-eighth inch of the true skin. The left flap was treated in same way, except that the paring was not severed at its lower connection; when the

sutures were put in, enough of this paring was saved to cover the under pared surface of the right flap.

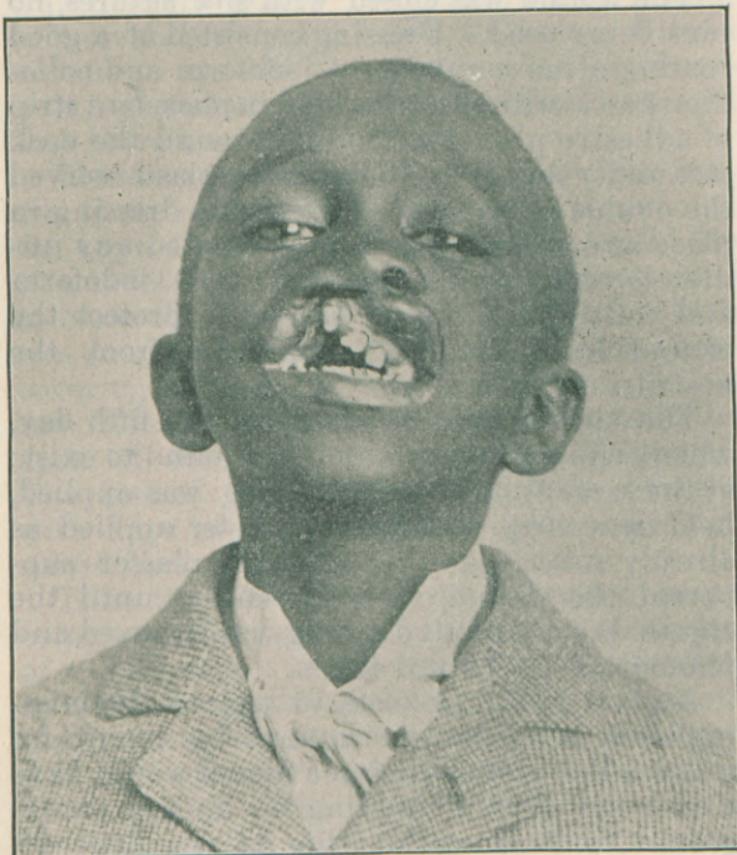
The wound was closed with silk sutures, no pins being used. Dressing consisted of a good coating of an emulsion of iodoform and collodion and sterilized gauze, held in place by a strip of adhesive plaster extending around the neck just under the ears. The adhesive plaster served the double purpose of holding the dressing in place and at the same time prevented any undue tension on the sutures. The iodoform and collodion emulsion served to protect the wound from the dirty secretions from the nostrils.

The sutures were removed on the fifth day, when perfect primary union was found to exist; at the same time a light dressing was applied, held by a strip of adhesive plaster applied as already described; this adhesive plaster supported the wound without tension until the eighth day, when all dressing was removed and photograph No. 3 was taken.

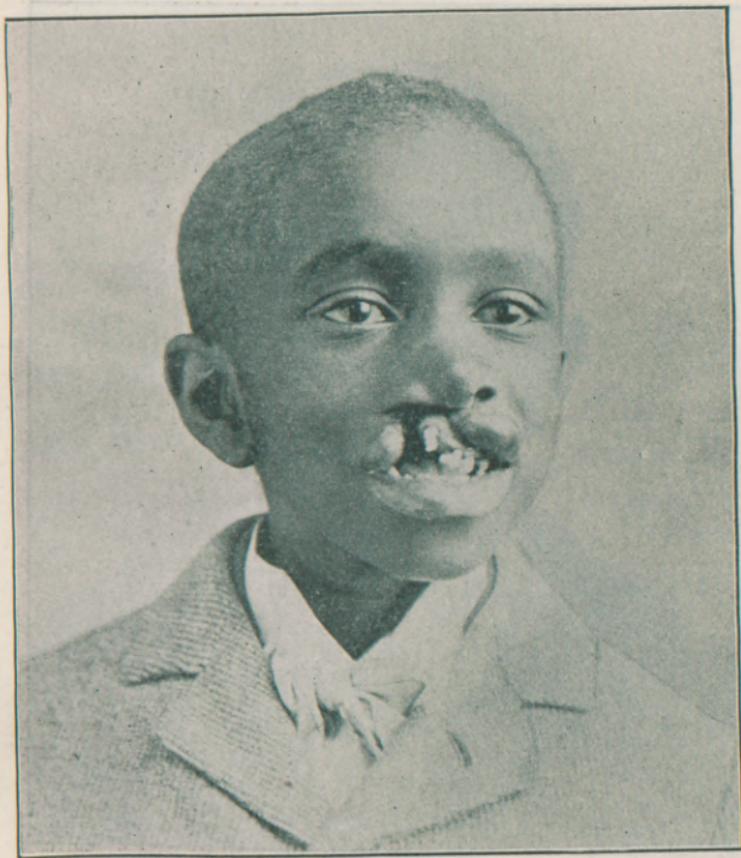
A plate with false teeth to replace the missing teeth is needed to improve his mouth for mastication, and at the same time it would have a cosmetic effect by holding the lip up; photograph No. 3 shows that the lip is a little depressed on the right.

In closing this report, I wish to render thanks to Dr. Arthur A. Snyder for the valuable assistance he rendered me while operating on this case.

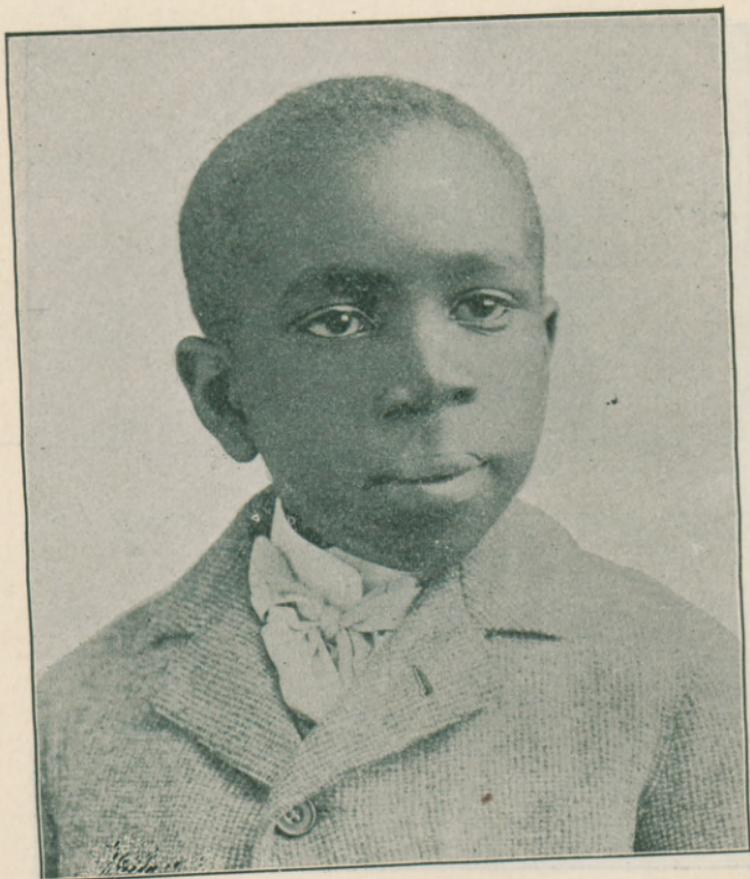
1305 H. St., N. W.



Photograph No. 1.



Photograph No. 2.



Photograph No. 3.

