be dampening the magnitude of statistical differences. To reframe the issue: our meta-analysis showed acellular dermis use results in higher complications; however, if industry relationships are skewing toward positive outcomes with acellular dermis, then the degree of difference in relative risk and pooled complication rates may be even higher. However, as Dr. Carlson himself acknowledges, industry affiliation may be itself a surrogate for other variables—perhaps earlier adoption, more experience, and higher volumes.

In fact, the true litmus test would come from inputs that are randomized and prospective in nature. We would not only look at negative outcomes but also integrate other potential outcomes, such as cost and aesthetics. However, as with many unresolved questions in plastic surgery, in the absence of definitive studies, we must often rely on the best available approaches to judge outcomes. The combination of a vigorous meta-analysis and full disclosure of potential conflicts can be a robust solution to this pervasive problem.

DOI: 10.1097/PRS.0b013e318263c7f1

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Fig. 1. Complication rate.

Table 1. DerSimonian and Laird Random Effects Model for Meta-Analysis of Postoperative Complication

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affiliation (yes vs. no)</td>
<td>6.16</td>
<td>2.31–16.4</td>
<td>0.0003</td>
<td>1.65</td>
<td>0.75–3.64</td>
<td>0.2165</td>
</tr>
</tbody>
</table>

HADM, human acellular dermis; OR, odds ratio; CI, confidence interval.

Fig. 1. Complication rate.

DISCLOSURE

Dr. Kim is a consultant for and receives research funding from Mentor and the Musculoskeletal Transplant Foundation. Dr. Fine receives research funding from Allergan. The remaining authors have no financial relationships to disclose.

REFERENCES


Z-Plasty on Levator Veli Palatini: A Modification of Sommerlad Palatoplasty

Sir:

We read with interest the article entitled “A Technique for Cleft Palate Repair” by Sommerlad,1 in which the author presented a good technique for cleft palate repair. Almost all cleft palate patients are now treated with Sommerlad palatoplasty in our department. We would like to offer a modification of this technique according to our own clinical experiences.

As we all know, the levator veli palatini is the main muscle that accomplishes velopharyngeal closure. There has long been a debate regarding whether the prolongation of soft palate length is needed in palatoplasty. The Sommerlad palatoplasty suggested a thorough dissection of the levator veli palatini, instead of prolonging the absolute length of the soft palate. It also suggested that the relaxing incisions should be made as minimal
as possible, and tension reduction of palatal soft tissue can partially be achieved through the reconstruction of the levator veli palatini. We have found clinically that the levator veli palatini has great potential; sometimes, it should not be dissected too thoroughly in case of a quite small tension between muscles on both sides after reconstruction, which cannot help in reducing tension of soft tissue. Furlow\textsuperscript{2} palatoplasty is the typical method of prolongation of the soft palate. Our department once conducted a randomized controlled trial with the inclusion criteria as follows: patients with occult cleft palate, older than 6 years, and velopharyngeal closure rate over 80 percent. Of 21 patients who met the standards, 11 were treated with Furlow palatoplasty, and nine of them showed velopharyngeal closure after surgery. The other 10 underwent Sommerlad palatoplasty, and only four of them showed velopharyngeal closure after surgery. This indicated that the prolongation of soft palate was necessary for those aged patients.

Sommerlad reported a velopharyngeal closure rate of 95 percent. However, his study focused only on young patients, whereas there are many aged patients in developing countries. According to the study by Satoh et al., the soft palate lengths in young patients had rather small differences compared with normal, and the differences increased gradually with age,\textsuperscript{3} which suggested that the aged patients should have their soft palates appropriately prolonged. Regarding the prolongation of soft palate on the basis of Sommerlad palatoplasty, our thinking was to use as an example the Furlow method for the essence of the prolongation of soft palate and to prolong the levator veli palatini: after a thorough dissection of the levator veli palatini, we made transverse incisions in the levator veli palatini on both sides, respectively; then, Z-plap cross-suture was carried out. There were three advantages to performing Z-plasty on the levator veli palatini: (1) the length of the levator veli palatini was prolonged, which was beneficial to the velopharyngeal closure; (2) the tension-reducing effect of the levator veli palatini was more significant; and (3) the stop point of the levator veli palatini could have a more complete recovery, with the rebound effect weakened. At the same time, the transverse tissue need not be sacrificed. In general, Z-plasty on the levator veli palatini combined the advantages of both the Sommerlad and the Furlow methods, and we think it is feasible.

According to histologic studies, the muscle fibers of the levator veli palatini on both sides overlap each other. Therefore, after Z-plasty, the levator veli palatini should become more to normal. In addition, Furlow palatoplasty itself is a cross-reconstruction of the levator veli palatini on both sides, and we performed reconstruction only in some key positions, so there was an advantage of a small wound and a good result.

DOI: 10.1097/PRS.0b013e318258f082

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DISCLOSURE
None of the authors has any relevant financial interests to disclose.

REFERENCES

Reply: Z-Plasty on Levator Veli Palatini: A Modification of Sommerlad Palatoplasty

Sir:

I thank Yang et al. for their letter. It is good to see surgeons thinking about how to improve palate function. As the authors say, patients undergoing palate repair after the age of 6 years are a challenge. First, they are likely to have acquired poor patterns of articulation that may require prolonged speech therapy. Second, as the authors point out, the nonfunctioning palate is likely to be shorter than if it had been repaired earlier (although all cleft palates are shorter than normal). Third, being unable to produce velopharyngeal closure, it is probable that the muscles function poorly in many patients.

There may well be a case for lengthening of the palate in late primary repairs. The Furlow technique is an option that enthusiasts for this procedure would advocate. Others lengthen the palate in older patients with single or double buccinator flaps introduced between the hard and soft palate.

I do not believe that lengthening is necessary in the majority of younger patients. The authors misquote me. I emphasized that secondary surgery rates (in my series, 5.9 percent with 10-year follow-up) do not equate in my, or any, series with the incidence of velopharyngeal incompetence. They depend on the following:

- The threshold of the team.
- The wishes of patients.
- Inclusions/exclusions.
- The length and completeness of follow-up.