

Correspondence

RE: LE FORT III OSTEOTOMY FOR MIDFACE DEFICIENCY IN SELECTED CLEFT PALATE PATIENTS

Denny and Bonawitz are to be congratulated on re-opening the discussion of high osteotomies in cleft patients (*J Craniofac Surg* 1994;5:295-303). There are certainly some patients who will profit from it [1], although their number is decreasing as a result of better primary surgical and orthodontical treatment. It certainly need not be a routine procedure [2], but on the other side the midface osteotomy should be tailor-made [3, 4]. After the development of the Le Fort type III osteotomy by Tessier [5] and Obwegeser [6] who were the first to describe the combination of types III and I, other combinations have been developed by others.

There is no doubt that in cleft patients hypoplasia or retropositioning of the upper half of the midface may be present, requiring in some cases correction by a quadrangular [7] or a Le Fort type II [8] osteotomy. A (pseudo-) exophthalmos is usually not seen; therefore, a Le Fort type III osteotomy seems not to be warranted. However, the configuration of upper and lower halves of the middle third often requires different amounts and directions of movement, thus forcing us to combine the high midface osteotomy with a Le Fort type I osteotomy. This also avoids the disproportional lengthening of the nasal root discussed by Wolfe [2]. The problem in cleft patients, however, is that the maxilla is advanced in two or three segments if the residual clefts have not been closed earlier. These (small) segments, in combination with the rather small upper segment of the Le Fort type II especially, can make proper stabilization quite difficult. This is one of the indications for me to perform a Le Fort type III and I osteotomy. It is easier to stabilize, which becomes even more important if an uncalled-for fracture line develops. It is evident that the osteotomy in the lateral orbital wall has to start on a very low level to avoid enophthalmos. Additionally, the walls must be reconstructed with care.

Denny and Bonawitz show better occlusal results than others [10-12]. On the zygomaticonasal level, results are considered stable on average [9, 12], but the statement that occlusal results are better in Le Fort types III and I than in type III enbloc [9] is questionable [4, 12].

In conclusion, as long as osteotomies en bloc can be used, the Le Fort type II osteotomy will be the highest level needed for the correction of the retruded midface of cleft patients. As soon as segmentations of the middle third seem desirable, a switch to the Le Fort type III level may be considered for technical reasons.

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