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## Preface

In the first page of the first edition of this book, I quoted Samuel Pruzansky who, after participating at an International Symposium on Cleft Lip and Palate held in 1969, and reflecting on what he heard at that meeting, stated, “The same tired questions have been asked as at every similar clinical meeting. And I despair at the general unfamiliarity with the pertinent literature.”

Fortunately, since the 1950s, many clinical investigators in the field of cleft palate have performed excellent clinical studies of the management of cleft lip and palate that have contributed to the intellectual ferment over the last 50 years. To these studies we are indebted, since to know this literature is vital for correct treatment planning.

When selecting significant references for this text, every attempt was made to carry out an exhaustive literature search to include all of the excellent articles on each subject covered. That, however, has been an insurmountable task. To investigators whose research articles were not included, I apologize and I advise readers to conduct their own literature search, which must include papers on the “opposing schools” of thought. There is no doubt in my mind that their final conclusions will be the same as mine when they consider the results of long-term palatal and facial growth studies that involved the analysis of objective records.

To familiarize clinicians with the appropriate literature and its importance to the treatment of cleft lip and cleft palate, the chapters in this book are structured to improve clinicians’ understanding of the natural history of the cleft defect, the face in which it exists, the influence of surgery on palatal growth and development, and equally importantly in developing an appreciation for the heterogeneity that exists even within a single cleft type.

These chapters will show that chronological age is not the parameter that really matters in determining the age at which to close the cleft in the palate. What is important is morphologic age and physiologic fitness, that is, whether the tissues are adequate in quantity and quality and whether the geometric relationship of cleft parts is favorable or unfavorable for reconstruction. Some questions incidental to growth, which date back 25 years, concern the relationship of the malformed palatal segments to the contiguous skeletal anatomy, which, in turn, may be anomalous. These following questions are also addressed: Are the palatal segments static in their deficiency or does the deficiency diminish in time, that is, is “catch-up-growth” a predictable phenomenon? And if so, what surgical procedures (as to age and type) make it possible?

Many of Pruzansky's thoughts, written so many years ago, still hold true today and are worth repeating. He stated that whoever sees things from their beginning will have the most advantageous view of them. To that end, most of the serial cases presented in this volume start soon after birth when plaster casts and photographs of the palatal and facial defect are taken. Serial lateral cephaloradiographs are added as soon as the child is manageable, and again taken periodically through adolescence.

It is hoped that clinicians who are just beginning their involvement in cleft palate will learn the pathology and its natural history of cleft palate from the cases presented in this book and appreciate the need to keep careful records (casts, cephaloradiographs, photographs, and panoraxes) which are of vital importance to both the processing of knowledge and self-criticism.

One last note of great importance – it is rare that two members of a team, such as I, an orthodontist, and D. Ralph Millard Jr., a plastic surgeon, can successfully work together even when some differences in treatment philosophy exist. We succeeded because we were professionally compatible and because we shared an obsessive need to determine why some procedures are successful and why others fail even when the same treatment procedures were used. Failures, we discovered, occur principally because of misinterpretation of physiological principles and/or a lack of technical proficiency.

Dr. Millard understood the value of serial objective records dating from birth as the essential starting point in determining the long-term utility of any surgical cleft treatment program. Although I was always free to voice a contrary opinion as to what surgery should be performed (and when), our working relationship was based on recognizing the right of the surgeon to reject recommendations and follow his own dictates. And it was my right, as a member of a team involved in growth studies, to document the anatomical changes to the face and palate for future analysis. Respecting our mutual rights and responsibilities was no simple task. Strong emotional and conceptual barriers had to be overcome in the process of communicating with each other.

Our 40-year search for a better understanding of the natural history of cleft lip/palate growth and development and the effects of various surgical-orthodontic treatment procedures ultimately led Dr. Millard to a conservative approach of staged surgical treatment without the intercession of maxillary orthopedics with periosteoplasty, which he tried and found wanting.

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## Reference

- Pruzansky S (1969) Early treatment of cleft lip and palate. In: Cole RM (ed) Proceedings of the second international symposium. Cleft Lip and Cleft Palate Institute, Northwestern University School of Dentistry, Chicago, p 116



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