

part of postoperative management, we suggested that the postoperative patient routinely use a Rotoresta bed. This air-cushioned bed lowers pressure on the wound so that the patient can rest in the supine position without damaging the flap. Using the bed also eliminates the need for rotating the patient, which both reduces the patient's discomfort and frees the nursing staff.

In closing, we recommend using this flap technique, and we emphasize the modification of doubling the layers in the midline as the treatment of choice for closure of sacral ulcers.

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FUNCTION OF THE INFRAHYOID MUSCLE FLAP

Sir:

We agree with Dr. Remmert et al.¹ that an important advantage of using a neurovascular infrahyoid muscle flap is the ability to maintain the shape of the tongue, to prevent scarring and atrophy of the reconstructed tongue, and to allow active movement. In our examination of the rat, the ansa cervicalis innervating the thyrohyoid muscle showed concentrated bursts in swallowing, irrelevant to respiration (Fig. 1).

However, functional issues remain. First, complications in the donor site of the infrahyoid muscle flap could be negli-



FIG. 1. Efferent discharges (ED) from the central cut end of the thyrohyoid muscle branch of the ansa cervicalis, showing the bursts in swallowing, which prevents inspiration. EMG, electromyogram. Ext. int. m., external intercostal muscle.

gible. How was the movement of the flap constructed, by only the sternohyoid muscle, which does not show active movements despite of contain of a number of spindles?² Electromyography of a reconstructed tongue could be influenced by the remaining tongue, because the presence of electrical activity in the reconstructed tongue does not seem to indicate voluntary muscle shortening. Perhaps the sternohyoid muscle innervated by the ansa cervicalis is thought to be unable to substitute the activity of the intrinsic muscles, or the activity of the geniohyoid muscle in the suprahyoid muscles, even if the sternohyoid muscle is attached to the mental spine.

Second, we feel that the geniohyoid muscle innervated by the ansa cervicalis is not associated with active voluntary movements during various functions, but a hypopharyngeal dilator in breathing as suggested by van Lunteren et al.,³ that is, upper airway patency. How was the aspiration in swallowing in patients in whom the geniohyoid and/or the genioglossal muscles were removed?

Such data of voluntary movements will help answer a question of the functional role of the infrahyoid muscles and the ansa cervicalis in the human. The activity of the flap should be observed longitudinally.

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EXPERT WITNESSES

Sir:

Dr. Habal has written an excellent editorial entitled "Responsibility, Integrity and Clinical Experts" (*Plastic and Reconstructive Surgery*, 99, 1134, 97), which should be read and endorsed by all of us.

For years I have advocated that expert witnesses should be "experts." They should not be paid by one side or the other, because that places them in an adversarial position, and they usually end up saying what their lawyers tell them to say.

Experts should be appointed to serve the court in the area of their expertise. Only then will justice be served. Our society should take the lead in abolishing the old system of guns for hire.

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