A new technique, with an unconventionally long and medially based flap from the upper anterior chest and shoulder, is used without any delay to minimize the difficulties entailed in reconstruction of the pharynx and cervical esophagus following their resection for cancer. (The SCI® indicates that this paper has been cited in over 280 publications. It is the most-cited paper published in this journal.)

The deltopectoral flap was developed, not through basic investigation in a laboratory setting, but through improvisation at surgery in Roswell Park Memorial Institute. One day, in 1959, I let our resident perform what I thought was to be simply a laryngectomy with neck dissection, but a larger cancer than had been estimated at endoscopy occurred to me that the rather short and low gap could be bridged by an acromially based pectoral flap (commonly used for cover on lateral neck defects) more advantageously than by the customary methods of flap design based on the idea that the vascular basis for the pectoral skin. The plan worked without a hitch, and gradually thereafter I began to establish the extraordinary usefulness of this unorthodox flap, not only in pharyngoesophageal reconstruction but also in most other head and neck areas of major reconstruction, internal or external, between the brow and the clavicle.

When I submitted the paper to Plastic and Reconstructive Surgery, it was promptly returned with a query from the editor, wanting to know if I had any other than the three representative cases I had included, since it seemed to him dangerous and "foolhardy" to employ such a very long and medially based flap without preliminary delay of any kind. I responded with data from the rest of the first 9 or 10 cases I had done, and the paper was published in 1965. It has been cited frequently because it has come to be regarded as a milestone that provoked a fundamental rethinking of the vascular basis for flaps, culminating in the distinction (made by McGregor and Morgan in 1973) between flaps "axially" designed along known anatomical blood supply, in contrast to the "randomly" designed flaps of yore requiring multiple stages for tubing and safe migration to the area of reconstruction.


