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FURTHER EXPERIENCE IN THE EARLY SIMULTANEOUS REPAIR OF CLEFT LIP AND PALATE

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It is now almost 10 years since we first began to perform the simultaneous repair of cleft lip and palate during early infancy (Kaplan *et al.*, 1974). The initial results were so encouraging that we rapidly adopted this as the routine procedure for infants born with this deformity. Our experience and the results which we have achieved with this approach, form the basis of this progress report.

MATERIALS AND METHODS

A total of 35 infants with congenital cleft lip and palate have undergone surgical repair in our department. At the time of operation, their ages ranged from 3 to 8 months, the mean age being 4 months. Children with anaemia or those with associated anomalies such as the Pierre-Robin syndrome were operated on later than the age of 3 months. The palate was closed without fracturing the hamuli, using a Langenbeck procedure (Kaplan *et al.*, 1978) and the lip was closed using a Le-Mesurier or Millard type of repair. All bilateral clefts of the lip were repaired at one sitting.

In evaluating the results, 7 children were excluded due to physical or mental retardation or geographical difficulties in arranging a follow-up examination. The remainder were kept under close review at the Cleft Palate Clinic, by an orthodontist, speech therapist, social worker, paediatric psychologist and educational consultant in addition to the plastic surgeons.

RESULTS

Assessment of the results so far obtained has led us to make the following conclusions:

1. Psychosocial Aspects. The early simultaneous repair of the lip and palate improved the oral satisfaction derived by the infant and strengthened the child-parent relationship. Maternal over-protectiveness was significantly less and so too was the anxiety normally shown by the child under the stress of a surgical intervention and in his attitude to the medical staff (Wirls, 1971).

2. Maxillary Growth. Eight of the children had preoperative orthodontic treatment with an expansion device, along the lines recommended by Burston (1965). No collapse of the maxillary arches was observed postoperatively. Occlusion and dentition were normal. The only postoperative orthodontic device which had to be used was a plate designed to stabilise a floating premaxilla in 6 children.

3. Otitis Media. The incidence of otitis media in those children who had undergone early closure of the cleft palate was no higher than in normal children.

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4. Speech. The 28 children kept under long-term follow-up were divided into 2 groups: *A*, 7 children aged 1-2 years, and *B*, 21 children aged 2-7 years. In group *A* assessment of the preverbal vocalisation showed it to be normal except for 2 infants with dull mumbling, possibly due to the low intelligence of the parents. Westlake and Rutherford (1966) have stated that cleft palate children usually have delayed vocalisation and dull mumbling. In group *B*, assessment of nasality, phonation, intelligibility and fluency of speech showed speech to be excellent in 11 children and satisfactory in 9, with only 1 patient classified as having poor speech because of delay and nasality.

5. Economic Aspects. An obvious advantage of simultaneous repair of the lip and palate is the reduced cost of hospitalisation.

CONCLUSION

In our opinion the good results in speech and midfacial growth obtained in these children following early simultaneous repair of the cleft lip and palate fully justify the adoption of this surgical approach in the treatment of infants with this congenital abnormality.

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