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An Evaluation of Surgical Outcome in Bilateral Cleft Lip Using Modified Millard Approach

Khan, Mahabubur Rahman

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AN EVALUATION OF SURGICAL OUTCOME IN BILATERAL CLEFT LIP USING MODIFIED MILLARD APPROACH



THESIS SUBMITTED FOR THE DEGREE

OF

DOCTOR OF PHILOSOPHY

IN THE INSTITUTE OF BIOLOGICAL SCIENCES UNIVERSITY OF RAJSHAHI BANGLADESH

BY

MAHABUBUR RAHMAN KHAN

JANUARY, 2020

January 2020 MOLECULAR BIOLOGY AND MOLECULAR PATHOLOGY LABORATORY INSTITUTE OF BIOLOGICAL SCIENCES UNIVERSITY OF RAJSHAHI RAJSHAHI-6205 BANGLADESH

MAHABUBUR RAHMAN KHAN

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 $\mathbf{B}\mathbf{Y}$

MAHABUBUR RAHMAN KHAN

Session: 2015-2016

JANUARY, 2020

MOLECULAR BIOLOGY AND MOLECULAR PATHOLOGY LABORATORY INSTITUTE OF BIOLOGICAL SCIENCES UNIVERSITY OF RAJSHAHI RAJSHAHI-6205 BANGLADESH

HUMBLY DEDICATED TO ALL CLEFT PATIENTS THROUGHOUT THE WORLD, ESPECIALLY MY BROTHER WHO BORN WITH A CLEFT LIP AND PALATE.

DECLARATION

I do, hereby declare that, the thesis entitled "An Evaluation of Surgical Outcome in Bilateral Cleft Lip Using Modified Millard Approach" for the degree of Doctor of Philosophy in Medical Science, contains no material, which has been submitted for the award of any other degree or diploma in any university. To the best of my knowledge and belief it contains no material previously published of written by any other person or any other forms except when due reference is made in the text of the thesis.

(Mahabubur Rahman Khan) Signature of the candidate

CERTIFICATE

This is to certify that the thesis entitled "An Evaluation of Surgical Outcome in Bilateral Cleft Lip Using Modified Millard Approach" has been prepared by Mahabubur Rahman Khan under my guidance and supervision for submission to the Institute of Biological Sciences (IBSc), University of Rajshahi, Bangladesh for the award of the degree of Doctor of Philosophy in Medical Science. It is also certified that the materials included in this thesis are the original works of the researcher and have not been previously submitted for the award of any degree or diploma anywhere.

I have gone thoroughly through the draft of the thesis and found it acceptable for submission.

Supervisor

Co-supervisor

Dr. Tanzima Yeasmin Professor Dept. of Biochemistry & Molecular Biology University of Rajshahi Rajshahi-6205. Dr. Al Mamun Ferdousi Professor & Former Dean Dept. of Oral & Maxillofacial Surgery BSMMU, Dhaka, Bangladesh.

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Mahabubur Rahman Khan.

Contents

Declaration	i
Certificate	ii
Acknowledgement	iii-iv
Contents	v-vii
List of Table	viii
Fist of Figure	ix-x
Abstract	X1
Abbreviations	X11
Chapter One:	1-19
1. Introduction	1
1.1 Cleft lip and palate	
1.1.1 definition of cleft lip and palate (cbl/p)	4
1.1.2 causes of cbl/p	
1.1.3 prevalence of cbl/p	
1.2 classification	
1.2.1 anatomic and morphologic perspectives	
1.2.1.1 j.s davis, m.d.; h. P. Ritchie (1922)	
Chapter Two:	20-21
Chapter Two: 2. Rationale, aims and objectives	20-21
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study	20-21 21
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims	20-21 21 21
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives	20-21 21 21 21 21
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives	20-21 21 21 21 21 21 21 21 21
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives 2.3.1. General Objective 2.3.2. Specific Objectives	20-21 21 21 21 21 21 21 21
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives 2.3.1. General Objective 2.3.2. Specific Objectives Chapter Three:	20-21 21 21 21 21 21 21 21 21 21 21
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives 2.3.1. General Objective	20-21 21 21 21 21 21 21 21 21 21 21
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives 2.3.1. General Objective	20-21 21 21 21 21 21 21 21 21 21 22 22
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives 2.3.1. General Objective	20-21 21 21 21 21 21 22 22 22 22 22
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives	20-21 21 21 21 21 21 22 22 22 22 22 22 22 23 25
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives 2.3.1. General Objective 2.3.2. Specific Objectives 3. Literature Review 3.1 Epidemiology	20-21 21 21 21 21 22 22 22 22 22 22 23 25 26
Chapter Two: 2. Rationale, aims and objectives 2.1. Rationale of the study 2.2. Aims 2.3. Objectives 2.3. Objectives	20-21 21 21 21 21 21 22 22 22 22 22 23 25 26 28

3.6.1 Dental Abnormalities	30
3.6.2 Speech pathology	30
3.6.3 Bones of the skull and face (Craniofacial) morphology	31
3.6.4 Bones of the skull and face (Craniofacial) morphology of	
adult with un-operated BCL/P	31
3.7 Environmental influences	32
3.8 Surgical Procedure	33
3.9 Diagnosis	34
3.10 Treatment	35
3.11 Conclusion	39
Chapter Four: 4()-45
4. Materials and Methods	40
4.1. Type of the Study	40
4.2. Place of the Study	40
4.3. Study Period	40
4.4. Study Population	40
4.5. Sampling	40
4.6. Inclusion Criteria	40
4.7. Exclusion Criteria	41
4.9. Methodology	41
4.9.1. Data Collection	41
4.9.2. Ethical approval	41
4.9.3. Statistical Analysis	41
4.9.4. Surgical Procedure	42
Chapter Five: 46	5-71
5. Results	46
5.1. Types and Detection of Bilateral Cleft lip	48
5.2. Lip Structure of Bilateral Cleft lip Subjects Before surgery	50
5.3. Length and Size of Lip-Nose Measurements of Bilateral Cleft lip	
Subjects Before surgery	52
5.4. Lip-Nose Correction of Bilateral Cleft Lip after Surgery	56
5.5. Length and Size of Lip-Nose Structures of Bilateral Cleft lip Subjects	•
Before and After Surgery	65
5.6 Post-Surgical Scaring and Bilateral Cleft Lip Repair	70

Chapter Six:	72-81
6. Discussion	72
Chapter Seven:	82
7. Recommendation:	72
Reference Appendices	83-98

LIST OF TABLE

Table No.	Title	Page
Table 1	Morphologic Classification Schemes of Brophy (1923) and Veau (1931)*	10
Table 2	Conditions for an "Ideal" Classification System*	18
Table 3.1.	List of the genetical abnormalities normally or irregularly introduced with either CBL or iCP (Shprintzen, 2002).	24
Table 5.1:	Demography and Characteristics of Bilateral Cleft Lips (BCL)	47
Table 5.2:	Types and Detection of Bilateral Cleft lip of the study subjects.	49
Table 5.3:	Nature of Bilateral Cleft lip Subjects Before surgery	51
Table 5.4:	Length and Size of Lip-Nose Structures of Bilateral Cleft lip Subjects Before surgery	53
Table 5.5:	Comparison of Lip-Nostril Corrections of Bilateral Cleft Lip before and after Surgery.	58
Table 5.6:	Follow up of Length and Size of Lip-Nose Structures of Bilateral Cleft lip Subjects Before and After Surgery	66

LIST OF FIGURE

Figure No.	Title	Page
Fig.3.1	Inheritance Pattern of Cleft Lip	26
Fig.3.2	Incidence of Bilateral Cleft Lip and Palate.	27
Fig. 3.3	Muscular configurations of the lips. Green: musculus orbicularis oris, orange: musculus levator angulis oris, yellow: musculus zygomaticus minor & major, blue: musculus levator labii superioris, purple: musculus depressor labii inferioris, red: musculus mentalis	29
Fig.3.4	Dental Anomalies of Bilateral Cleft Lip	31
Fig.3.5	Surgical Procedure of a Bilateral Cleft Lip Patient by Modified Millard Techniques	33
Fig.4.1	Ugly lip formation (Other techniques)	42
Fig.4.2	Before Surgery	43
Fig.4.3	After Surgery	43
Fig.4.4	Before Surgery of a Complete Bilateral Cleft Lip	44
Fig.4.5	After Surgery of a Complete Bilateral Cleft Lip by Modified Millard Techniques	44
Fig.4.6	Before and After Surgery of a Complete Bilateral Cleft Lip by Modified Millard Techniques	44
Fig.4.7	Scar Formation of Vermillion Border by Manchester Techniques.	45
Fig.5.1	Bar Diagram showing Bilateral Cleft lip of the study subjects.	49
Fig.5.2	Bar Diagram showing Lip Structure of Bilateral Cleft lip Subjects Before surgery	51
Fig.5.3	Length and Size of Lip-Nose Structures of Bilateral Cleft lip Subjects Before surgery.	54
Fig.5.4	Bar-Diagram Showing Condition Vermilion Border of Bilateral Cleft Lip Subjects before Surgery	54
Fig.5.5	Bar-Diagram Showing Condition of Cupid'S Bow of Bilateral Cleft Lip Subjects before Surgery	55

Fig.5.6	Bar-Diagram Showing Condition of Philtrum of Bilateral Cleft Lip Subjects before Surgery	55
Fig.5.7	Line-DiagramShowingAverageLipWidth/Thickness of Bilateral CleftLip after Surgery	59
Fig.5.8	Bar-Diagram Showing Average Lip Length of Bilateral Cleft Lip after Surgery	59
Fig.5.9	Bar-Diagram Showing Average Lip Height of Bilateral Cleft Lip after Surgery	60
Fig.5.10	Bar-Diagram Showing Average Nostril Width of Bilateral Cleft Lip after Surgery	61
Fig.5.11	Bilateral Cleft Lip and Palate Repair by Modified Millard's Techniques	62
Fig.5.12	Facial Cleft (Bilateral Cleft) repair by Modified Millard's techniques.	63
Fig.5.13	Lip-Nose Structures (Bilateral Cleft) repair by Modified Millard's techniques.	64
Fig.5.14	Bar-Diagram Showing Vermilion Border Bilateral Cleft lip Subjects Before and After Surgery	67
Fig.5.15	Bar-Diagram Showing Cupid'S Bow Bilateral Cleft Lip Subjects Before and After Surgery	67
Fig.5.16	Bar-Diagram Showing Philtrum Bilateral Cleft Lip Subjects Before and After Surgery	68
Fig.5.17	Nasal Cleft Repair by Modified Millard's Techniques.	69
Fig.5.18	Length and Size of Lip-Nose Structures of Bilateral Cleft Lip Subjects Before and After Surgery by Modified Millard's Techniques.	69
Fig.5.19	Pie-Chart Showing Post-Surgical Scar Mark After Surgery	70
Fig.5.20	Post-Surgical Repair of Bilateral Cleft Lip and Palate.	71

ABSTRACT

To handle premaxilla of Bilateral cleft lip cases is the biggest challenge for a surgeon. All the post-operative complication arises only at this area. Like labial fistula, fibrosis, scaring, inadequate development pre-maxilla causing incompetent lip etc.

So, our art, technique and concentration for bilateral cleft lip surgery based on premaxillary work. Here is the modification of modified millard's techniques-

To save 2-3 mm mucous layer of premaxilla, the tissue which is discard by other techniques like Manchester techniques. Handle that tiny tissue; carefully place it in correct position which will give a long term excellent aesthetic surgical outcome.

In Bilateral cleft lip cases always the premaxilla is short. We design and dissect and lengthen 1-2 mm and shape the upper lip with normal length.

Mobilize the mucous layer from both sides, close the opening of cleft alveolus and built up a very good sulcus layer.

This will help the normal development of premaxilla and will prevent the postoperative complication of bilateral labial fistula which is very common complication of bilateral cleft surgery.

Abbreviations

ABG	:	Alveolar bone grafting
ACPA	:	American Cleft Palate-Craniofacial Association
ALFH	:	Anterior lower face height
ATFH	:	Anterior total face height
AUFH	:	Anterior upper face height
CBCLP	:	Complete bilateral cleft lip and palate
CFA	:	Craniofacial anomalies
CLP	:	Cleft lip and palate
CL/P	:	Cleft lip with or without cleft palate
СР	:	Cleft palate
СТ	:	Computed tomography
CUCLP	:	Complete unilateral cleft lip and palate
DI	:	Digital image
DICOM	:	Digital imaging and Communication in Medicine
DPI	:	Dots per inch
DMA	:	Dentomaxillary advancement
ICC	:	Intraclass correlation coefficient
IQ	:	Intelligence quotient
IVV	:	Intravelar veloplasty
JPEG	:	Joint Photographic Experts Group
NAM	:	Nasoalveolar molding
PSIO	:	Presurgical infant orthonedics
RCT	:	Randomized control trial
SD	:	Standard deviation
SD UCLP	:	Standard deviation
SD UCLP WHO	:	Standard deviation Unilateral cleft lip and palate World Health Organization

Chapter-I

INTRODUCTION

1. INTRODUCTION

To born as a normal human being is a blessing. A baby is born with congenital facial defect (cleft lip) in this world to face challenges one after another is their whole life. Immediately after birth a new born cleft baby struggle with breathing problem to intake and adjust the extra volume of air breathing every moment with extra wide nasal space which is not normal.

Then come to feeding, A new born failed to suck the breast milk due to lack of natural oral assistance approaches (lip, cheek, and chin support) might assistance with facility of a steady stage for vigorous activities of the tongue, lips, and cheeks for the period of sucking efforts (Clarren *et al.* 1987; Hwang, Lin, Coster, Bigsby, & Vergara. 2010). Due to feeding and breathing problem can be disturbed, the normal growth of cleft baby. CBL (Cleft on the both side of the lip) seems at what time the arrangements of the lip and or palatal shelves failed to fuse among the eight and twelfth weeks of pregnancy (Pearson & Kirschner. 2011).

So, CBL are the very common abnormalities and might or might not be present in the perspective of orofacial inherited abnormalities and/or craniofacial disorders (Arvedson & Brodsky. 2002; Cooper-Brown *et al.* 2008; Shprintzen *et al.* 1985). Difficulties with nourishing procedure and management of breathing and swallowing might take place with isolated CBL, but are generally transitory in nature (Masarei *et al.* 2007). In compare, nourishing and swallowing problems could be important in the situation of difficult craniofacial abnormalities secondary to upper airway obstruction, cranial nerve deformities, and neuromotor factors (Arvedson & Brodsky. 2002; Cooper-Brown *et al.* 2008; Kummer. 2013; Perkins, Sie, Milczuk, & Richardson. 1997). Disorganized nourishing might cause in insufficient capacity of oral consumption, poor weight gain, and eventually negotiated nutritious and growing status. In addition, airway obstacle as a effect of the craniofacial abnormality might cause an incapacity to attain or tolerate airway protection for the period of feeding and swallowing, posing a possible danger to respiratory health (Dinwiddie. 2004). At very early age, cleft patient face another challenge of painful surgery one after another. That painful suffering can be more when post-surgical complications arise. At school age more challenges are also come that is isolation, rudeness, noncooperation by other childrens and teachers.

In Bangladesh these cleft patient are often called " $\pm VvuU KvUv/Zvjy KvUv$ ", in

India they are called "Lord Ganesha" in Kenya, are called "Mdomo sungura" (Rabbit face), In Somalia, "Faruro", In Rwanda, "Kabali" etc. That is their biggest psychological trauma in their life. As a result these cleft children refuse to go to school, refuse to play with other children. At the age of marriage, there is more painful sufferings from in laws family, insultation, mental and physical torturing, even sometimes separation of life. That's the reality of cleft patients. Cleft is a most-frequent congenital birth. Facial defect affecting 1 in every 500 to 1000 birth world-wide, varies in different races. Like Asian, European and African. One baby is born with cleft every two minute in the world according to WHO study published in 2000. Cleft is a greek word means a space or opening made by cleavage or split. BCL&P is a cleft which involves base of the nose, the upper lip. the alveolar process. hard palate and soft palate.



1.1 CLEFT LIP and PALATE

A **CBL/P** is an initial or split in the upper lip which happens when development of the facial arrangements in an unborn baby don't close by totally. CP might be CSL or CBL. A newborn with a CP may possibly experience a cleft in the roof of the mouth (cleft palate).

CSL and CBL are the outcome of tissues of the face not assembly correctly during the growth phase. (Facts about Cleft Lip and Cleft Palate. 2014) Although, it is a kind of genetic deficiency (Facts about Cleft Lip and Cleft Palate. 2014). The cause is unknown in most cases (Facts about Cleft Lip and Cleft Palate. 2014). Threat issues consist of smoking during gestation, diabetes, obesity, an aged mother, and few drugs (example: few used to treat seizures). (Facts about Cleft Lip and Cleft Palate. 2014) CSL and CBL may frequently make a diagnosis during gestation with an ultrasonography examination (Facts about Cleft Lip and Cleft Palate. 2014).

A CSL and CBL may be effectively treated with surgical treatment (Facts about Cleft Lip and Cleft Palate. 2014). That is frequently completed in the first few months of life for CP and before 1 year and 6 months for CP (Facts about Cleft Lip and Cleft Palate. 2014). Language therapy and dental carefulness might also be required (Facts about Cleft Lip and Cleft Palate. 2014). With proper management, results is good (Facts about Cleft Lip and Cleft Palate. 2014)

CBL & P occurs in about 1 to 2 per 1000 births in the developed world (Watkins *et al.* 2014). Cleft Lip is around two times as common in males as females, whereas Cleft palate without Cleft Lip is more common in females (Watkins *et al.* 2014). The disorder was previously identified as a "hare-lip" because of its similarity to a hare or rabbit, but that term is currently considered to be unpleasant. (Boklage ,Charles E. 2010).

1.1.1 DEFINITION OF CLEFT LIP AND PALATE (CBL/P).

CBL/P is among the most general genetic situations (Vanderas. 1987; Clinical Standards Advisory Group. 1998; Mosey and Little. 2002). In common terms, cleft lip is the occurrence of a couple of upright opening in the upper lip and alveolus. It might differ since a minor deficiency to a whole cleft spreading up to and concluded the bottom of the nose. Whereas cleft with palate exists in the existence of one upright opening in the palate. CBL/P was supposed to happen while the appearance procedures in an embryo did not entirely fused. The working meaning for CBL/P had been well-defined that arising as a cleft on the either side of the lip and palate or cleft lip with or without cleft palate (CBL/P) or a cleft palate without lip (CP) (ICBDMS. 2001). The main cleft sub-types are isolated cleft lip (CL), cleft lip and alveolus (CLA), cleft palate only (CP), unilateral incomplete cleft lip and palate (IUCLP), unilateral complete cleft lip and palate (UCLP), incomplete bilateral cleft lip and palate (IBCLP) and bilateral complete cleft lip and palate (BCLP). Common improvement of the oral fissure starts around the 4th week of gestation, a absence of combination of the primary palate in the 5th week of gestation displays as cleft of the lip and alveolus whereas absence of union of the secondary palate during the 8th week of gestation outcomes in cleft of the palate (Sperber. 2002).

1.1.2 CAUSES OF CBL/P

The reason of CBL/P is not well assumed but there is a solid hereditary relation, intricate through the relations of a collection of eco-friendly and way of life features for example nutrition or smoking (Murray. 2002). The multifactorial idea of reason and outcome of CBL/P had established by detecting the aetiological heterogeneity in a series of occurrence of CBL/P. Several are initiated by altered genes, others as a outcome of chromosomal irregularities, precise ecological mediators and a decent number is produced by a communication among genetic factor and ecological issues (Mossey. 2009; Botto. 2002; Butali. 2011). CL/P is supposed to be genetic; the legacy trait had showed by researches on relatives and mongoloid twins (Douglas. 1958; Asling *et al.*1960). The chief cleft sub types are isolated cleft lip (CL), cleft lip and alveolus (CLA), cleft palate only (CPO), unilateral incomplete cleft lip and palate (IUCLP), unilateral complete cleft lip and palate (BCLP).

Relationship among ecological threat issues and CBL/P for example parental contact to tobacco, liquor, malnutrition, infection, medicinal drugs and teratogens had investigated, with maternal smoking and lack of folic acid being steadily connected with the danger of emerging clefts (Mossey *et al.* 2007).

1.1.3 PREVALENCE OF CBL/P

Cleft lip and palate arises more regularly than sequestered cleft lip and sequestered palate (Calzolari *et al.*, 2007, Tolarova and Cervanka. 1998). Normally CL/P occurs men more than women (Niswander *et al.* 1972; Ritter *et al.* 2004). In case of Gender distribution of cleft lip and palate finds that isolated cleft lip was more usual in men while isolated Cleft palate was common in women (Rittler *et al.* 2004)

The universal occurrence of CBL/P was 1:700 live births (WHO. 2002). Greater frequency had described between Asians through an occurrence as high as 2 per 1000 (Gorlin *et al.* 2010). In the Chinese a frequency of 1.12 per 1000 had noted (Cooper *et al.* 2000). These statistics were marginally upper than a cleft occurrence of 1 per 1000 stated in White British (CRANE Project Team. 2009). Minor occurrence 0.3-0.9 per 1000 live deliveries had described amongst the black residents (Butali *et al.* 2009). However it hard to determining accurate occurrence in the black group due to bias in procedure and reporting (Mossey *et al.* 2009). The occurrence of clefts in the diverse cultural group was not identified (Hernandez-Diaz. 2000).

The World Health Organization in its sequence of reports on global joint investigation on craniofacial irregularities described on the occurrence and incidence of clefts (WHO 2002, 2003). In overall, cleft on the both side of the lip with or without palate and sequestered cleft palate had an incidence of about 1 in 700 live births (WHO. 2002). It is similarly explicated that though alterations amongst republics do exist, birth incidence of CP (with or without CP) was about 1:1000 births. Further, in two thirds of patients identified with cleft, the left-hand side was more recurrently affected, and it was more widespread in men than in women (WHO. 2002).

Greater frequency of CL/P had described amongst Asians whereas small frequency had described amongst African residents. In Europe, researchs had discovered that 1.45-1.57 in each 1000 persons were born with cleft lip and/or palate (Derijcke *et al.* 1996). In a research of all Danish offspring with clefts born among the years of 1976 and 1981 the frequency was 1.89 per 1000 live births (Jensen *et al.* 1988). It had problematic in establishing the incidence of CL/P in Nigeria, due to beneath reporting; earlier researchs had described a frequency of among 0.2-0.3 per 1000 (Iregbulem *et al.* 1982). A very current research had stated an occurrence of 0.5 per 1000 (Butali *et al.* 2011).

1.2 CLASSIFICATION

Cleft on the both side of the lip and palate (CBL/P) were categorized according to their phenotypes or appearances. Classification of CBL/P based on this phenotypic appearance. Imprecise and unreliable classification remains a problematic nowadays. So, requirement for a classification which is simple, universal, and practical.

Classification of CBL/P is difficult because of their appearances is phenotypically diverse. This thesis discovers the advancement of concepts about CBL/P catagories and includes the patterns termed by Veau (1931), Harkins *et al.* (1962), Fogh-Andersen (1943), Brophy (1923), Spina (1973), Kernahan and Stark (1958), Davis and Ritchie (1922), Broadbent *et al.* (1968).

1.2.1 ANATOMIC AND MORPHOLOGIC PERSPECTIVES

1.2.1.1 J.S Davis, M.D.; H. P. Ritchie (1922)

Davis and Ritchie move on further than simply applauding suspension of the word harelip. Davis and Ritchie were amongst the leading supporter for appropriate classification scheme. They discussed, that, there are no usually recognized normal expressions for analyzing hereditary CBL/P, and, in result, it is frequently hard to recognize the explanations in several of the papers transcribed on that CBL/P. Some researchers may practice a set of expressions to define few of these disorders, whereas other might practice the similar expressions to analyze those disorders which are practically dissimilar. Yet again an investigator might have a set of expressions which, it seems on research, which investigator alone practices and the person who reads might have to rest on on the explanations to discover what is actually expected by the script. In circumstance, the expression is significantly confused. Classification proposed by J.S Davis, M.D.; H. P. Ritchie is very easy and simple. It is consists of 3-group methods that acceptable discrete explanation of the lip, palate and alveolus. Classifications were given below:

Group I: Pre-alveolar cleft lip (lip is affecting by the clefts)

- (1) Unilateral (complete/incomplete: right/left)
- (2) Bilateral (left: complete/incomplete; right: complete/incomplete)
- (3) Median (incomplete /complete)

Group II: Post-alveolar cleft lip (palate is affecting by the clefts)

(1) Hard palate

(2) Soft palate

Group III: Alveolar cleft (alveolar process is involving the cleft)

- (1) Unilateral (complete/incomplete: right/left)
- (2) Bilateral (left: complete/incomplete; right: complete/incomplete)
- (3) Median (incomplete / complete)

As CBL/P phenotypes might include several arrangements, J.S Davis, M.D.; H. P. Ritchie permitted similarity of the classifications. Precisely, they approved that CBL (alveolus intact) is verified as both group I and group II; nonetheless, each and every situation concerning an alveolus cleft (regardless of the integrity of the lip or palate) would be characterized completely as group III. Additional analysis, it is seeming that J.S Davis, M.D.; H. P. Ritchie accepted that for instance a topic of ambiguity (if not weakness) in their grouping system: In the 3rd group, there is frequently an connected cleft of the (alveolar) procedure, lip and palate of several steps structurally; but there must be contained within that situation, of flexible incidence, in which a CBL and cleft procedure are existing with a usual palate, or, if those incidents arise, of a CP and cleft procedure with a usual lip. The suitable grouping of these incidents is a topic for argument. That would be more achievable to record them in the 3rd cluster as there the prospect is specified for the straight explanation of the 3 structures. (J.S Davis, M.D.; H. P. Ritchie, 1922).

Their idea that the alveolus made the foundation of an "smart arrangement" was not globally recognized and was reason for much argument. Nonetheless, J.S Davis, M.D.; H. P. Ritchie's suggestion was established positively by presentday specialists such as James Thompson of Galveston, Texas, whom went on record to say that "there is great need of development in arrangement and terminology and that the system [by J.S Davis, M.D.; H. P. Ritchie] is a stage in advance" (J.S Davis, M.D.; H. P. Ritchie, 1922).

Vilray Blair of St. Louis was thoughtfully kept in that certification of the new system:

it is thoroughly in kindness with and vigorously accept of the complete thought but it is trying to scheme roughly for worldwide adaptation. Although it is not totally accepted, it is not meaningful; and, to guarantee its acceptance, so, it's requires the finest strategy. As it is not, someone would exist something a slight superior, distressed the one which have to accepted and went on. (J.S Davis, M.D.; H. P. Ritchie,1922) Blair's main disapproval of the grouping scheme was its origin on current clinical viewpoints (that was issue to be changed) rather than on anatomy alone (which is immutable):

Dr. Ritchie sets onward that the grouping will be alongside clinical outlines, leaving the anatomic outlines. Permitting that, the clinical grouping system had the better application; the anatomic source is much stable. Classification built on a clinical idea that had not hoisted the experiment of time.

Brophy (1921 to 1923)

T.W. Brophy (Chicago) resound Blair's feeling that appropriate classification would be established on appropriate accepting of anatomy; he was relatively verbal in assessing the Davis and Ritchie scheme as it is inadequately meticulous in this respect. In 1921 and 1923, Brophy issued his personal meticulous research of the formulas of CBL/P founded on unbelievable 5076 and 2676 operations to renovation CP (Cleft lip and palate) (Brophy, 1921). The purpose was to justification for "each muscles and bones intricate in that

malformations'' (Davis and Ritchie, 1922). Therefore, the grouping comprised 16 separate morphological forms of CP (Cleft lip and palate) with/without (Table 1). Brophy's classification were mentioned by the Annals of Surgery (McWilliams, 1924), but numerous specialists measured the method excessively multifaceted and impractical.

BROPHY			VEAU
1	RAS	A very simple system of cleft palate, just a partial cleft of the uvula.	<i>"Division de la luette"</i> (division of the uvula)
2		A cleft spreading forward into the fibres of the levator palate and the replicated portions of the tensor palate muscle; which gives the complete anatomic form.	1° Forme " Divisions simples du voile" (simple divisions of the velum)

TABLE 1	Morphologic	Classification	Schemes of	f Brophy (1923	6) and	Veau
(1931)*						

3	A cleft spreading through the uvula and forward to the posterior border of the horizontal plates of the palate bones.	I	
4	A cleft spreading through the complete soft palate, including partial or whole cleft of the horizontal plates of the palate bones		
5			2° Forme "Divisions du voile et de la voûte" (divisions of the velum and vault)

6		Π	
7	A complete single cleft of the total soft and hard palate, as well as the alveolar process; the maxilla is separated from the pre-maxilla, usually on the left side, and escorted by single harelip.	ш	3° Forme "Divisions du bec-de- liêvre unilateral total" (divisions of the complete unilateral harelip)

8	-	A tripartite cleft, spreading	4° Forme
		through soft and hard palate, separating the pre- maxillae from the maxillae; nearly always complicated with double harelip.	IV "Divisions du bec-de- liêvre bilateral [total]" (divisions of the [complete] bilateral harelip)
9		A cleft of the entire soft palate, extending through the horizontal plates of the palate bones and into, though not through, the palatal plates of the maxillae. (The pre- maxillae are divided from the maxillae, between which and the anterior part of the cleft, the hard palate is normal; it is usually difficult with double harelip.)	<i>"Division du voile dans le bec- de- liêvre bilatéral total"</i> (Divisions of the velum in bilateral complete harelip)

10	(manual)	A cleft only among the	"Bec-de- liêvre unilatéral total
		maxilla and premaxilla, usually on the left side and escorted by single harelip.	<i>sans division palatine</i> " (complete unilateral harelip without palatal division)
11		A cleft entirely splitting the pre-maxillae from the maxillae, with the palate otherwise normal.	<i>"Bec-de-liévre bilatéral total sans division palatine"</i> (bilateral complete harelip without palatal division)
12		A cleft only of the anterior one half or one third of the hard palate, with protruding pre-maxillae which are completely separated from the maxillae.	<i>"La fusion des lames palatines Ś est arrêtée `a la partie moyenne"</i> (fusion of the palatal shelves ceased in the midline)
13		A cleft of the complete soft and hard palate, spreading through the alveolar ridge on one side, with pre- maxillae detached entirely on one side and moderately on the other,	<i>"Fente unilatéral dans un bec- de- liêvre unilatéral total"</i> (unilateral cleft [palate] in a bilateral complete cleft lip)

14	(\mathcal{A})	A cleft of the soft palate, incomplete or complete, usual hard palate with cleft	"Bec-de-liévre uilatéral total avec division palatine isolée de la fente du rebord alvéolaire"
	Ja	in the alveolar border.	(unilateral complete hare lip limited to a fissure in the alveolar ridge with palatal division)
15		A cleft only of the alveolar process anterior to the maxillae, due to the improvement or absence of the pre-maxillae, usually accompanied by harelip in the median line.	<i>"Bec-de-liévre bilatéral total sans tubercule médian avec intégrité de la voûte palatine"</i> (bilateral complete harelip with absent median tubercle and an intact palatal vault)
16	An exceedingly rare separating in the medi	e form, a cleft entirely an line the entire palate and	n/a
	lip.		

* Brophy's (1923) system was very detailed but arguably too complex for practical use. Veau himself commented that Brophy's classification featured a numerous countless "variétés de la même forme" ("varieties of the similar type") and aimed to simplify the classification into one that was more utilitarian and clinically significant. Veau I encompasses Brophy classes 1 to 3, Veau II encompasses Brophy classes 4 to 6, Veau III corresponds with Brophy class 7, and Veau IV corresponds with Brophy classes 8 (and arguably 13). Differences among the Brophy classes within these groupings are really matters of severity. Brophy classes 9 to 16 are other combinations of CL+P that are not considered by the Veau classification, which was limited to describing clefts of the palate (CP) only. According to Veau, "Pour ma part, je m'y refuse absolument . . . ils sont opérés comme des becs-de-liévré ordinaire et non comme des divisions palatines" ("For my part, I absolutely refuse [to classify them] . . . they are operated upon like ordinary harelips and not like palatal divisions.") Figures reproduced from Veau V. Division Palatine. Paris: Masson; 1931. Permission granted by Elsevier-Masson press.

Veau (1931)

Victor Veau (1931) issued milestone separation palatine, that is called the method to estimation and managing of CP. Veau was humble of Brophy but willingly serious of the grouping scheme, testifying that it identified a numerous countless "variétés de la même forme" ("varieties of the identical type") that would be assembled together.

Veau's significantly shortened grouping of palatal clefts contained of four morphological systems (Table 1):

I. The velum/ muscular palate

II. The velum/ muscular and hard palate, up to the perceptive foramen

III. The velum/ muscular and hard palate spreading one side of the lip through alveolus

IV. The velum/ muscular and hard palate spreading both side of the lip through alveolus

Despite the fact that Veau argues the most difficult of anatomical outcomes in Separation Palatine, so decisively selected to eliminate "confounding" specifics (severity) since the grouping scheme itself, favoring modest classifications. In the following study devoted to cleft lip, Bec-de-Lièvres (Veau and Récamier, 1938), Veau avoids taxonomical classifications completely and in its place supports a perfect and brief explanation of the labial deficiency (containing laterality [one or both side of the lip /median] and level [simple/ total]). The simplicity, morphologic source, and scientific significance of Veau's method to classification through it very good-looking to the current specialists.

EMBRYOLOGICAL PERSPECTIVES

Fogh-Andersen (1942)

Classification given by Davis and Ritchie had one criticism and that was the alveolar procedure as separating mark among the pre-alveolar clefts and postalveolar clefts were indiscriminate. P. Fogh Andersen was a good doctor who measured the perceptive foramen, rather than alveolar procedure, to be a improved separating link from an embryological perspective.

In the article, Genetically Harelip and Cleft Palate (1942), this suggested an alternate to the Davis and Ritchie classification which was poised of four catagories:

- (1) Harelip (single or double)
- (2) Harelip with cleft palate
- (3) Isolated cleft palate
- (4) Rare atypical clefts, e.g., median cleft lip

Similarly J.S Davis, M.D.; H. P. Ritchie, Fogh-Andersen's cluster one clefts ("harelip") was anterior, but Fogh-Andersen, that intended the cleft were anterior to the perceptive foramen rather than to the alveolar procedure. Prominently, Fogh Andersen illustrious in the huge epidemiologic research that certain notch of labial clefting were consistently witnessed in connotation with separation of the alveolar procedure, advising that cleft lip and alveolus were related and perhaps related to the etiologically. So, Fogh-Andersen's cluster 1 ("harelip") efficiently contains cleft lip alone and cleft lip with cleft alveolus, and his cluster 2 ("harelip with cleft palate") incorporated cleft lip and alveolus with cleft palate (e.g., Veau III and Veau IV) although CBL with integral alveolus (e.g., cleft lip with a Veau I or Veau II cleft palate). Fogh-Andersen additional developed the characterization of an inaccessible CP (Cleft lip and palate) (group 3) as a deficiency that is "constantly average [which] certainly not touches further than the incisor foramen'' (Fogh-Andersen, 1971). That explanation is alike to a Veau I cleft of the soft palate only or a Veau II cleft of the secondary hard and soft palate. Veau III and Veau IV CP were automatically involved in cluster 2 since Fogh-Andersen assumed certain grade of labial clefting to be existent each and every time the alveolar procedure were disturbed.

Lastly, Fogh-Andersen added cluster 4 to seizure the average CBL that was formerly observed only as a occasional deficiency rather than as a classic but distinct type of CBL..

Kernahan, D.A. and Stark, R.B. (1958)

Kernahan D.A. and Stark R.B. (New York) has too reliable supporters for a cleft grouping scheme on developing anatomy. In 1958, they were providing support for Fogh-Andersen's usage of the perceptive foramen as the embryo-logically sound separating line by mentioning indication since the most existing accepting of facial embryogenesis:

Kernahan D.A. and Stark R.B. confronted the usage of morphology alone as a foundation for classification: "the embryologic actions prominent to the malformation, viz., the distinct nature and time formation of the primary and secondary palates, were well understood"; and thus, "cleft lip and palate preferably would be categorized on that basis" (Kernahan D.A.,1991).

Transformers were added to define laterality (unilateral/bilateral/median) and severity (total/subtotal). That nosological outline is closely equal to that of Fogh-Andersen, though the arrangement of the clusters is dissimilar. Kernahan and Stark comprised median CBL in their cluster 1 (anterior clefts) rather depend on a distinct catch-all classification for a typical clefts.¹

TABLE 2 Conditions for an "Ideal" Classification System*

I.	Concise, clear definitions of terms; hence,	
	A. Rejection of the meaningless, the ambiguous, and the irrelevant	
	B. Preference for simple, descriptive English terms	
	C. Retention of established customary terms, where possible, in order	
	to avoid duplication and confusion	
	D. Formation of new terms only where necessary	
	E. Indication of synonomous [sic] terms, especially those of wide usage	
	such as ones based on Latin or Greek, to facilitate comprehension	
	and use of the system proposed here	
П.	Convenience of use through:	
	A. Economy of expression	
	B. Logical arrangement of classification conformable with	
	1. Normal topographic (spatial) relationship of anatomical structures	
	2. Normal sequence in embryologic advent and union	

	C. Standardized methods of measurement
III.	Stimulation of scholarly and clinical research by:
	A. Standardized procedures for observation and reporting
	1. Meaningful in terms of embryologic antecedents
	2. Meaningful in describing tissue relationships used to evaluate
	need and method of therapy
	B. Provision for rare conditions

* In its 1962 report, the Nomenclature Committee of the American Association for Cleft Palate Rehabilitation published its principles for a perfect grouping system (Harkins *et al.*, 1962). These regulatory ideologies are still very valid.

¹ A current obligation of fetal facial improvement explains that a median premaxillary cleft is due to imperfect synthesis of the medial nasal eminences to arrangement the pre-maxillary section, Although the more common lateral cleft lip with/without cleft alveolus arises from abnormal synthesis of the right/left maxillary eminences with the pre-maxillary section. In this light, a method systematized stringently allowing to embryologic ideologies should indeed categorize median labial clefts independently from lateral labial clefts.
Chapter -II

RATIONALE, HYPOTHESIS, AIMS AND OBJECTIVES

2. RATIONALE, AIMS AND OBJECTIVES

2.1. Rationale of the study

A Modified Millard's Technique (without banking of lateral elements) for bilateral cleft lip cheiloplasty is a dependable and adaptable procedure connected with outstanding surgical outcome. The clinical results showed less scar formation, adequate length of the upper lip and reconstituted symmetrical nostrils.

The Millard's repair intricate complete elevation of the prolabium and reconstruction of the orbicularis through the premaxilla. In addition, Millard banked lateral sections of the prolabium as "forked flaps" that were meant to add collumellar height at a later stage.

This technique has more worldwide use and has been adjusted to give more acceptable clinical result, the banking of the lateral module of the prolabium however give unsightly scar especially in the dark-skinned individuals, which are more liable to to unnecessary scar formation.

A modification of this technique is therefore necessary to achieve a more esthetic result especially in this group of patients

2.2. Aims

The general aim of this study was to describe occurrences of cleft lip and evaluate the treatment outcomes in this unique group of patients.

2.3. Objectives

2.3.1. General Objective

The general objectives of this study was to review the surgical outcome of bilateral cleft lip surgery (BCLS) done using modified Millard's (fork flap) system.

2.3.2. Specific Objectives

- 1. Modified Millard's technique which is complete elevation of the prolabium and reconstitution of the orbicularis across the premaxilla without banking of lateral segments of the prolabium.
- 2. Evaluate surgical outcome that is Adequate length of the upper lip, symmetrical nostrils, reconstituted philtrum and adequate columella length.
- 3. To build up the foundation of surgery that is reconstruct the mucous layer by closing the fistula, increase the adequate length of sulcous which give a very good length of lip automatically.
- 4. To give a very good long form aesthetic view to the subjects/patients which will give him confidence and satisfied life.

Chapter-III

REVIEW OF LITERATURE

3. LITERATURE REVIEW

Cleft lip and cleft palate or both are the most common or facial inherited deformities found amongst live birth the causes of which are not clear but have a trend that includes 2 etiological factors, genetic and environmental (1 Murray. 2002). The purpose of the analysis is to mark the opinion in research knowledge about cleft on the both side of lip and/or palate (Bilateral cleft lip and/or palate). A Literature review of the universal journal/research work have been made to argue about the anatomical features, the epidemiology, etiology, hereditary and environmental factors, diagnosis and treatment of this malformations. The results of the cleft on the both side of the lip and/or palate (CBL/P) decrease within the utmost frequent inherited anomalies of the bones of the skull and face area. At present, lots of experimental and phonotypical structures of this abnormality, which vary allowing to the diverse structural arrangements involved. The etiological, hereditary and environmental situation which were not previously identified. To afford accurate identification and management is essential. A multidisciplinary exercise and involvement is essential for the medical group to explain these malformations. The relation among altered medical surgeons provides an acceptable care for the subjects and their relatives. The clinical management is the most shared action use for these deformities. along with the orthodontic management.

Nonetheless, the best action is hard to invention as of the huge inconsistency of that malformations and the individual response of each subjects to the treatment. Every argumentation has been separated by bearing in mind that the different problems registered above:

3.1 Epidemiology

CBL/P has a global prevalence of 1/700 live births (Pigott 1992). The extreme birth incidence ratio (1/500 birth) is described for the Asian and Amerindian residents. A transitional incidence rates (about 1/1000 birth) was described in

European residents, whereas the African residents has the lowermost occurrence (1/2500 birth) (Beaty *et al.* 2010; Christensen and Mitchell. 1996; Mossey *et al.* 2009). Cleft palate (CP) may possibly the only one pathology affecting the patient, whereas CBL (Cleft on both side of the lip) might be related or not with CP. Around 70% of all the CBL disorder and 50% of CP merely fall inside non-syndromic pathologies. Although syndromes are associated to cardiac, limb, ophthalmological and other. (Del Prete *et al.* 2014)

3.2 Actiology

CBL might be both a feature in patterns (Table 1) and out-of-the-way ones, termed non-syndromic cleft. Reasons of non-syndromic CBL still keep on imprecise (Mossey et al. 2009). Numerous researches had recommended an association among certain parental lifestyles for the period of the first trisemester of prenatal period besides the progress of a cleft. Near it was durable indication that parental smoking was associated with a greater than before danger of having CBL (Wyszynski et al. 1997; Little et al. 2004). Concerning nourishment, multi-vitamin enhancements were not established as being a defensive aspect (Loffredo et al. 2001). Several visceral researches have revealed that a nutrient insufficiency of folic acid and Zinc augmented the danger of consuming a cleft (Warkany & Petering. 1972; Bienengraber et al. 2001; Malek et al. 2004). Contacts to certain organic materials; for example, agricutural compounds, retinoids (Vitamin A derivatives), corticosteriods, some anticonvulsants drugs e.g. diazepam, carbamazipine, phenobarbital, or a viral contamination similarly proliferations the danger for clefts and other genetic abnormalities (Dolovich et al. 1998; Park-Wyllie et al. 2000; Acs et al. 2005; Romitti et al. 2007).

Syndrome	CLP	iCP
Craniofrontonasal disorder	normally	normally
Del (18p)	normally	normally
Ectrodactyly-Ectodermal dysplasia-Cleft lip and palate disorder	normally	normally
Filliform adhesions with clefting disorder	normally	normally
Niikawa-Kuroki disorder	normally	normally
Oculoauriculovertebral spectrum	normally	normally
Opitz disorder	normally	normally
Popliteal pterygium disorder	normally	normally
Trisomy 13	normally	normally
van der Woude disorder	normally	normally
Cri du chat disorder	irregularly	normally
Escobar disorder	irregularly	normally
Fetal Alcohol disorder	irregularly	normally
Hay-Wells disorder	irregularly	normally
Rapp-Hodgkin disorder	irregularly	normally
Treacher Collins disorder	irregularly	normally
Wolf-Hirschhorn disorder	irregularly	normally
Cryptophthalmos disorder	irregularly	irregularly
Down disorder	irregularly	irregularly
Oculodentodigi disorder	irregularly	irregularly
Robinow disorder	irregularly	irregularly

Table 1. List of the genetical abnormalities normally or irregularly introduced with

 either CBL or iCP (Shprintzen, 2002).

Hereditary influences are also significant. In non-syndromic CBL, certain development causes and metabolic enzymes such as TGFA, TGFB3 and MTHFR had been rigorously seen (Wong & Hagg. 2004; Zeiger *et al.* 2005; Vieira 2006; Mossey *et al.* 2009; Jagomagi *et al.* 2010). Genetical arrays had been defined for

relatives with conditions e.g. the van der Woude disorder. The gene TBX22, IRF6 and PVRL1, which reasonably connections with disorders, also associates to an occurrence of a non-syndromic CBL (Carinci *et al.* 2007; Park *et al.* 2007; Ferrero *et al.* 2010). It indications to assumption that a few genetic influence that associates to any syndromic CBL might possibly rapid the threats of having non-syndromic CBL (Wong & Hagg, 2004). Spontaneous mutations are possibly to have the occurrence for unusual diseases, with clefts/cracks as a feature, at a relatively stable all through periods. The investigation in genetic material-syndrome relationship is still a extensive puzzling arena for forthcoming investigation.

All these predisposing factors for cleft lip disorder but in reality it could be unknown factor or power (could be Allah) with reference of Quran Allah says in chapter 36 verse 82- "KUN FAYA KUN" (Be it will be).

So the cause of cleft lip could be "KUN FAYA KUN."

3.3 Role of Genetics

CBL/P is influenced by the achievement and the alteration of numerous and several genetic factor. The situation can also be liable of the modification of the genetic material or relate with genetic alteration, which is the reason for the malformations. The expression of the syndrome (syndromic and non-syndromic) have been associated to few deficient genetic material and their receptors (Riley and Murray. 2007), such as FGF8 and FGFR1 genes.

TGF β is one more domestic genetic material intricate in the development of the cleft on both side of the lip or one side of the lip, in specific: TGF β 3, with the inactivation of its receptor TGF3 β R2 (Lidral *et al.* 1998) and the inactivation of BMP7 (Zouvelou *et al.* 2009) (Wurdak *et al.* 2005). Several investigators verified the comprising of transcription factors in the pathogenesis of CBL/P: modification in MSX1 (Satokata and Maas. 1994) (van den Boogaard *et al.* 2000), TBX22 (Braybrook. 2001) and IRF6 (Zucchero *et al.* 2004). Parental

liquor consumption (Molina-Solana *et al.* 2013), parental direct and indirect tobacco smoking (Wyzynski *et al.* 1997, Sabbagh *et al.* 2015), parental illness through initial gestation (Hashmi *et al.* 2010) and some compounds for example contact with the antileptic medications: carbamazepine (phenytoin and valproic acid), thalidome, herbicides for example dioxin and retinoid acid had revealed to be teratogenic and reason genetic deficiencies and rises the danger for CBL/P (Brito *et al.* 2012). Gene-environmental relations with CBL had similarly broadly investigated. It had been recommended that environmental influences might interrupt the dangerous role of this genetic factor throughout the lip and palate creation (Brito *et al.* 2012, Mossey *et al.* 2009).



Fig.3.1.: Inheritance Pattern of Cleft Lip

3.4 Prevalence of Cleft Lip /Palate

The general prevalence of orofacial cracks is approximately 1 to 2.21 cases/1000 births. The occurrence of CBL and CBL/P differs amongst nations, socioeconomic position, tribal or cultural sets (Derijcke *et al.* 1996). Dependable statistics of prevalence was not obtainable in certain portions of the uiverse and there was relatively extensive variety among processes in altered nations. In overall the frequency of CBL and CBL/P in the European inhabitants was

greater than occurrence of cleft palate (Doray *et al.* 2012, Magdalenić-Meštrovic & Bagatin 2005). Incidence of CBL and CBL/P were abundant in Asia (China, Japan) and portions of Latin America and few in South Africa, southern Europe and Israel. Incidence of cleft palate was abundant in some region of Northern Europe (Finland, Norway) and Canada and few in some area of Latin America and South Africa (Tolarová & Cervenka 1998).



Fig.3.2: Incidence of Bilateral Cleft Lip and Palate.

Meanwhile 1963 all genetic deformities that had been identified throughout the 1st year of life or later had described to general catalogue (Rintala 1986). In Finland the total occurrence of CBL and CBL/P is 0.96 and the frequency of cleft lip is 1.36 per 1000 births. There is some local difference among dissimilar cleft categories. Common cleft type is Cleft palate which is found in Northern and Eastern Finland and CBL/P found in Southern and Western parts of Finland. The occurrence of Cleft palate in Oulu University Hospital (OUH) zone among 1993 and 2011 was 1.78 per 1000 childbirths and abortions and frequency of CBL/P was 1 per 1000 births and abortions (National Institute for Health and Welfare 2013). The incidence of CBL and CBL/P differs by sex and laterality. CBL/P was recurrent in men and sequestered cleft palates were frequent in

females (Stanier & Moore 2004). Splits involving the mouths ensue regularly on the left-hand sideways than the right-hand sideways in CBL and CBL/P cases (Blanco-Davila 2003, Hagberg *et al.* 1998, Jensen *et al.* 1988).

3.5 Anatomical features

The artificial muscles round the mouths are divided into double categories: the several portions of the orbicularis oris muscle and muscles that were round the orbicularis oris muscle. The muscle was separated into four fragments and every fragment resembles to one quadrant of the mouths. The muscle fibers didn't straightly attribute to jawbone and initiating on the profound external of the membrane, superiorly from maxilla and inferiorly from mandible. The orbicularis oris attachments into the mucous skin of mouths and muscle fibers in the philtrum and attribute on the nasal septum. The orbicularis oris performances as an oral sphincter containing mouths closure, protuberance and pressing. The superficial muscles of the superior lip were: the levator labii superior is, levator labii superior is alaeque nasi and zygomaticus main and minor. The levator anguli oris was a profound muscle of superior lip. The levator muscles upraise the superior lip and the zygomaticus muscles bump the lip domineeringly and sideways. The superficial muscle of inferior lip was the depressor anguli oris and the profound muscles of inferior lip were: the depressor labii inferioris and the mentalis muscle. These muscles were liable for dragging the inferior lip inferiorly and sideways and the mentalis muscle lifts and obtrudes inferior lip (Berkovitz et al. 2009, Baker 2010) (Fig 3.3.).

The insufficiency or the not-attached among maxillary and medial nasal procedures (36th/37th day of gestation) reasons labiomaxillary clefts (Delaire and Precious. 1986). These will lead to several phenotypes and medical presenting of the abnormality:

- Cleft Lip (CL): That abnormality will involve one side of the lip (unilateral) or both side of the lip (bilateral). This abnormality would be two types: complete or incomplete. The complete system, soft tissue disruption spreads among open edge of the higher lip and base of the nose with snags in skin, mucosa, bone and muscles totality and irregularity of nose (Farronato *et al.* 2014). The incomplete arrangement disturbs merely the open edge to the lip lacking include the nose and the entireness of the adjacent soft tissue.

- Cleft Lip and Palate (CBLP): CBLP are categorized by a fissuration which apprehensions upper side of the lip, maxillary bone, alveolar bone and hard/soft palate. There were dual types of cleft: the one side of cleft (CSL) and the bilateral type/CBL type. The CSL is classified by a fissuration to the alveolar bone among the lateral incisor and the canine guiding of the naso-palatine channel; So, CSL was the central of tough and soft palate generating an oronasal communiqué from the muscle movement of tongue on the palatal procedures (Farronato *et al.* 2014). The CBL is classified by the fissuration to both edges encounter in communication of the naso-palatine channel working on palate all the time in the central (Farronato *et al.* 2014).



Fig. 3.3: Muscular configurations of the lips. Green: musculus orbicularis oris, orange: musculus levator angulis oris, yellow: musculus zygomaticus minor & major, blue: musculus levator labii superioris, purple: musculus depressor labii inferioris, red: musculus mentalis

- Cleft Palate (CP): Cleft Palate is includes simply the palate: cleft hard and soft palate or cleft soft palate only. Commonly, fissuration advances to naso-palatine channel up to soft palate. To recognize this kind of modification was enormously

significant to decide and recognize the essential development and prospects of intercession on the muscles intricate and negotiated by the pathology.

Researches revealed in what way CBL systems have expressively better tissues insufficiency than the CSL and CP (Lo LJ *et al.* 2003), therefore they might be careful as the most severe arrangements to face in the multidisciplinary restoration.

3.6 Phenotypic Features of Bilateral Cleft Lip

3.6.1 Dental Abnormalities

Cleft patients/subjects face several dental abnormalities than persons deprived of CBL/P. Tooth agenesis, microdontia, malpositioned teeth, transposition, supernumerary tooth and numerous abnormalities were steadily recurrent in CBL/P subjects. Teeth impaction likewise inclines to be extra corporate. Concerning teeth agenesis, rejecting third molars, lateral incisors and premolars were maximum frequently scatterbrained through no substantial variances concerning every person's cleft position. Subjects lacking clefts extent extra agenesis of the lateral incisors. Teeth agenesis happens more recurrently in individuals with thorough CBL/P, cleft on the one side or both side of the lip, and also in those with incomplete cleft on the both side of the lip and palate (CBL/P and CP), when matched with persons without clefts. The deficiency of maxillary left lateral incisors was meaningfully related by cleft on the one side of the lip (right clefts). In compare, right lateral incisors were most usually lacking with cleft on the one side of the lip (left clefts). (Jugessur *et al.* 2009; Letra *et al.* 2007)

3.6.2 Speech pathology

Usual speech needs the muscles which mark up the velopharyngeal sphincter exertion in a co-ordinated technique. Deficiencies in some feature of the nasopharyngeal anatomy or physiology might bring to velopharyngeal stupidity, which was categorized mainly by irregularities in nasality (hyper- or hyponasality and nasal air emission). (Jugessur et al. 2009)



Fig.3.4: Dental Anomalies of Bilateral Cleft Lip

3.6.3 Bones of the skull and face (Craniofacial) morphology

The bones of the skull and face morphology were categorized by eminent premaxilla, a retrognatic maxilla, abridged posterior maxillary height and a minor, retruded mandible. The prolabium was lacking of some muscle threads. The nostrils were overextended, and the tip of the nose was broad. The columella seems to remain reduced or absent, and incase prolabium frequently appears to remain combined straight to the tip of the nose. (da Silva Filho *et al.* 1998)

3.6.4 Bones of the skull and face (Craniofacial) morphology of adult with un-operated BCL/P

- A prominent premaxilla which reasons an overset stretching starting 10 to 16 mm and that outcomes in a great facial convexity
- A minor mandible by an dangerous clockwise revolution in relation to the cranial base
- A reduced mandible through a perpendicular development design, outcomes in an obtuse gonial viewpoint and a extended anterior inferior face height

- A conspicuous premaxilla and minor mandible, causing in dangerous anteroposterior inequality among the jaws
- ✤ A propensity near retro-clination of incisor teeth in together jaws
- Lesser proportions of the cranial foundation, but no modification in cranial base angulation
- Compact posterior facial height. (da Silva Filho et al. 1998)

Upper dental arch morphology:

- Sexual characteristics had difference outcome on the maxillary arches of cleft and without cleft subjects; important modifications were existing in without cleft subjects (wider and longer arches in men), but not in the unoperated subjects.
- Mature with un-operated BCL/P had an anteriorly advanced tightening to the superior dental arch in together sexual category and a meaningfully lengthier maxillary dental arch, that was recognized to the premaxillary frontal prognosis. (da Silva Filho, de Castro Machado. 1998).

3.7 Environmental influences

The surrounding environment can firmly impact the extent of these deformities. Parental smoking is the primary peri-conceptional time which reason the alteration of some genetic material, manipulating metabolic pathways and the progression of that malformation (Little *et al.* 2002) (Shi *et al.* 2008) (Shi *et al.* 2007) (Wu *et al.* 2010).

High alcohol consumption in peri-conceptional period can increase the risk (DeRoo *et al.* 2008), and teratogens for example valproic acid could be related with Cleft Palate (Jentink *et al.* 2010). Although nourishing deficiency can stimulus the risk of CBL/P, for example folate insufficiency (Johnson and Little. 2008), but further researches is needed, in the upcoming, to clear up this characteristic which sign to the actual effects. New ecological disclosure for example contaminations, radiation, anxiety, fatness and hyperthermia could

reason for CBL/P (Shahrukh Hashmi et al. 2010; Mossey et al. 2009; Mossey et al. 2007).

3.8 Surgical Procedure

The lip connection technique according to Millard procedures in patient with a CBL (Fig.3.5). When designs the incision-lines, the flaps inside the prolabial island are planned horizontally separation a philtrum of closely usual form and measurement. The prolabial vermilion rests intact. On occasion, particularly in subjects with a very extensive premaxilla, it was essential to spread the opening to the nasal vestibulum beside the piriform opening, to organize the alar sources, which had to be situated on maximum of the premaxilla and to be stable to the anterior nasal spine.



Dissect prelabium or premaxilla



Dissect prelabium or premaxilla



Sulcous formation and clouser of labial fistula



Very good Length of sulcous

Fig.3.5. Surgical Procedure of a Bilateral Cleft Lip Patient by Modified Millard Techniques

While all edges and all flaps were scratch and organized, the first phase of the restoration was to injection the alar bases into the premaxilla at the anterior nasal spine. By dragging together the alar bases to the midline the cleft margins adjacent in the prolabium, whereas the vermilion edges could be locked and form the back of the initial lip restoration. The following phase was to introduce the flaps onto the subalar gap.

Lastly the skin of the lateral lip rudiments is sutured together with two or three mattress sutures, which run crosswise the prolabial island. The most cranial cross-suture has to be hanged around the anterior nasal spine.

There was not at all essential for suture elimination as the superiority of the scar was immaterial. It was smoothly superior to leave the sutures, to avoid the smallest amount of danger of wound break down. (**Bitter. 2001**)

3.9 Diagnosis

The diagnosis of CBL could be completed in several stages: antenatal and perinatal stages (Farronato *et al.* 2014). It requires a multidisciplinary method, because numerous experts can be involved in the analysis. Anomaly scan is currently identifying CBL in uterus since around 22 week of pregnancy, although if wrong positive and missed defects had described. This technique could be failed in case of minor CBL; orofacial (OFCs) splits are frequently not revealed till delivery. It is evident that the gynaecologist acts important part for early identification (Kaufman. 1991; Strauss. 1999).

Throughout the pregnancy period, sub-mucous clefts of palate might be existent, but it is very tough to identify initially (McWilliams. 1991). The initial identification in pregnancy period permits the parents to a multidisciplinary carefulness group for an appropriate counseling and help. If CBL/P is identified

in pregnancy periods it could be useful to organize for a neonatologist or a pediatrician to be presented at the time of delivery to identify possible respiratory complications or other hereditary abnormalities (Farronato *et al.* 2014).

A pediatrician has to detect and approve the structural deficiencies and to regulate the medical procedure of the deformity. In the perio-natal stage the oral cavity and the entire palate must be well observed. Tongue depressor and palpation were suitable techniques to differentiate submucosal changes. The existence or not- existence of tooth, gradation of hard and soft palate clefting, existence or not- existence of the uvula, indication of pitting of the lips or palate, nasal spitting out of fluids, a bifid uvula or a luminous crucial region in palate were extra significant symbols for the pediatrician (Habel *et al.* 1996).

Other physical abnormalities are occasionally related with CBL for example velopharyngeal inadequacy (VPI); if the precise examinations used to disclose these malformation were affirmative, operation is suggested. It was clear that the significance of a watchful investigation of the newborns in delivery chamber, to detect any airway or physical complications that could be advised a related hereditary disorder (Arosarena. 2007).

3.10 Treatment

The limited times of lifecycle are the ideal for the main valuation of the adolescent by CBL team. The ultimate management strategy of carefulness is conveyed in a group consultation and talked to the family of the youngster. Consistent observing by the carefulness group was suggested, to witness the development and future ear, nose and throat, speech and developing problems (Kasten. 2008).

It was significant to quickly recommend the parents around the birth of a kid through a genetic deficiency. Specialists or a pediatrician must support them and transfer the update immediately possible. Preferably the parents must be interconnecting with associate to the multidisciplinary carefulness group inside 24 hours of delivery (Kasten. 2008). At first period next to the birth, the maximum significant difficulties that could be proficient were breathing and breastfeeding problems. Distinct training and care must be provided to parents, and a lactation specialist or speech therapist would work by parents (Habel *et al.* 1996).

The fabrication of baby plates (presurgical orthopedics) (Winters and Hurwitz. 1995) is requested as a useful scheme for breast-feeding development and simplification of CBL restoration. Currently there was no indication to care or dishonor any of this statements and the training rests empirical. Additional techniques to support youngster and parent with feeding difficulties were special magnums and teats, manufactured in an extensive diversity, demonstrating the obstinate complications experienced by clinicians. Nasogastric suckling is not every time mandatory and it would be evaded if thinkable. In its place, a nasopharyngeal airway is crucial in case of impediment and either austere breathing difficult due to the anatomical deformities.

The ideal technique and method for the operating interference differs reliant by the center inspected. Maximum of the British center restoration lips 3 months afterward natal and palate among 6 to 12 months. The pre-surgical orthopedic procedures might be used. Casting strategies are positioned to support change the alveolar segments. This might be engaged in combination with the membrane redraping with nasal alveolar molding.

Other wordy technique was the "functional repair" by Delaire (Smith *et al.* 1995). Several oral-maxillofacial physicians supporter of this technique influence improved results for mid-face development compared with methods frequently functional by plastic surgeons. Besides, cross research in Europe revealed a reduced outcome for the purpose technique related to the common technique achieved by plastic surgeons.

A significant portion of the lip restoration comprises nasal recontouring and restoration of the sphincter of the lip. Again, efforts were completed to reestablish the nasal thickness if required (Farronato *et al.* 2014). Restoration of the CP (cleft palate) is generally completed after 9 months of age. In earlier, operation was implemented about 4-6 y of age, but this was harmful for the patient's speech improvement. It was suggested to execute surgical procedure when the kid initiates to improve plosives "b, d and g" in speech (at about 11-12 months of old) (Farronato *et al.* 2014). Operating modification may be essential, but they have to be implemented after the complete total curing has happened and tender tissues have become softer (Winters and Hurwitz. 1995).

In preschool ages the main complications are: language and verbal improvement, ear nose and throat observing, somatic progress and improvement, and common dental health. In certain subjects, straight afterwards operation, consequent speech disorders can happen, needing numerous intrusions (around 75% of patients) all through juvenile and teenage years to succeed satisfactory language construction and verbal competency (Winters and Hurwitz. 1995; Habel *et al.* 1996; Witzel *et al.* 1984).

Features that might be caused language syndromes are: dental and occlusal difficulties, oro-nasal fistulas, hearing complications and velo-pharyngeal inadequacy. Kids with CP are topic to the identical reasons that motivation the language and speech improvement in patients lacking clefts: neural, perceptive, progressive, environmental, and sensitive guidance (Sell *et al.* 1994).

The treatment of language and speech patterns could be operating or nonoperating, by means of palatal working out appliances, language bulb, biofeedback language treatment or an obturator. Generally the language improvement happens about 6 years of age, and this is the greatest time to start language treatment (Winters and Hurwitz. 1995) and to observe language improvement frequently with an orthodontic and clinical supervision (Farronato *et al.* 2012). The orthodontic treatment of dental deformities generally arises in the school age years, till maturity. In the beginning, no vigorous orthodontic management was mandatory, but the orthodontist could intricate in the assembly of a palatal obturator to relief in nurturing for the period of initial stages. The orthodontist is firmly intricate in the therapy with the discharge of the primary and permanent dentition. In specific, if the cleft includes the alveolar development the teeth might be irregular, twisted, and supernumerary or lacking.

A systematic appearance at the dentist and decent oral hygiene was suggested. A vigorous occlusal management was to elude up to stable dentition was recognized (Habel *et al.* 1996). For the period of the school years orthodontic treatment, alveolar bone grafting and emotional supports were the chief involvement in subjects with CBL. The alveolar bone grafting creates a normal alveolar design by which tooth could explode and consequently relocated orthodontically.

All through these techniques the specialists could likewise restoration and adjust fistulas and the presence of the nose. In subjects through several lip and palate operations the maxillary development could be improved and subsequent in a hypoplastic maxilla and fatten up mid-face. The insignificant cases could be operated only with an orthodontic usage, whereas the main and austere maxillary insufficiencies are operated with Le Fort I advancement (the similar method for insignificant and bigger discrepancies). These kinds of intercession are generally done after the whole development and mature of the face, to evade a another intervention.

Through the school years, the orthodontist had a significant role. The ultimate orthodontic management could development 3 to 4 years afterward bone grafting stage (about 12-13 y). Management of the initial mixed dentition frequently includes maxillary partial braces and maxillary development. Time and again patients with CBL improve a maxillary retrusion that can be operated with an anterior orthopaedic protraction.

Development before bone grafting was superior, and leads to finest outcomes in specific in strictly restrained arches (Winters and Hurwitz. 1995). In the child age, completely the emotional difficulties and complications in community relationships might operated with a self-acceptance treatment and encouraging association with parents.

Throughout teenage years, the orthodontist might operate with orthodontic applications entirely the residual difficulties regarding tooth arrangement. In this time could similarly seem certain conflict not apparent earlier. Few research's on adults revealed that the initial palatal operation could liable for such development difficulty of the face, but this management is essential for an acceptable language progress during childhood (Cagáňová *et al.* 2014).

3.11 Conclusion

CBL (Cleft on the both side of the lip) are genetic deficiencies that disturb several arrangements and roles for example language, inhalation, nourishment, esthetics, development and growth of the craniofacial region. The actual etiology was still unidentified, but ecological and hereditary influences were intricate in that malformation. There was not only one phenotypes or medical image regarding that malformation, and that was why was still so tough to discover a distinctive way to resolve and management this deformity. The expression could be diverse and dependent by the specific and even the management can lead to altered effects reliant by each patient's situation, even in patients with the same deformity. Perhaps there are numerous methods to achieve a decent outcome. All operations can regulate scar tissues that could be change and prevent the regular facial development. The technique of the clinical involvement was verbalized through useful and esthetics features, and also through the development age. It was clear that a clinical involvement to rebuild the irregular constructions was essential to assurance an acceptable development and purpose. Greatest outcomes were gained with operating and orthodontic management.

Chapter-IV

MATERIALS AND METHODS

4. MATERIALS AND METHODS

4.1. Type of the Study

Retrospective observational study.

4.2. Place of the Study

1. Madaripur Sadar Hospital and International free surgical Camp in Bangladesh.

2. Emergency Observation ward, Dhaka Dental College, Dhaka.

4.3. Study Period

June 2015 to December 2018

4.4. Study Population

The subjects of this research were CBL/P patients who were treated at the Dhaka Dental College, Dhaka, International free surgical Camp in Bangladesh and Madaripur Sadar Hospital, Bangladesh during the study.

4.5. Sampling

Random sampling considering exclusion and inclusion criteria of patients in the study.

4.6. Inclusion Criteria

• The following inclusion criteria was considered for selection of the study sample.

Patients born with complete bilateral cleft lip.

- All cases were done under general anaesthesia with orotracheal intubation.
- Patients with a soft tissue band up to 5mm in width were included.
- Only patients whom their parents gave voluntary consent were selected.

4.7. Exclusion Criteria

- Patients who present with other types of cleft than complete Bilateral Cleft lip.
- Patients with Unilateral Cleft lip.

4.9. Methodology

History and clinical examination of the patients was performed.

- The study period was from June 2015 to December 2018.
- A total of 75 BCL patients were taken for study.
- All these patients were evaluated thoroughly by History, Clinical and Laboratory methods.

4.9.1. Data Collection

All demographic, clinical and laboratory data were recorded in a pre-designed data collection sheet.

4.9.2. Ethical approval

The research protocol was accepted by the institutional review board of Rajshahi Medical College, Rajshahi. Informed written consent was obtained from each patient attendant after briefing about the research. Data were collected in an approved data collection form.

4.9.3. Statistical Analysis

The collected data was checked and coded manually and entered into a computer. The numerical data obtained from the study was examined and significant difference calculated by using statistical methods. Data was stated in frequency, percentage, mean \pm SD as applicable. Chi-square test, student's t-test and Fishers exact test or others were used for comparison between groups as applicable. All data were analyzed by using computer based SPSS (statistical program for social science) program version 17.0 for Windows. P-value of less than 0.05 was considered statistically significant.

4.9.4. Surgical Procedure:

As bilateral cleft surgery is always challenging. Due to abnormal anatomical position of pre-maxilla or pre-labium, same tissue. Pre-labium is too short or too much protected.

And long term post-operative aesthetic outcome is not that satisfactory. Some surgeons believe and practice if you dissect the pre-labium it might necrossed.

Some surgeons practice the right and left side cleft tissue to join with pre-labium without any rotational advancement of orbicularis muscles.

The long term impact of this practice will be shortening of pre-labium and make very ugly in competent lip formation.



Fig.4.1 Ugly lip formation (Other techniques)

Some surgeons practice only closure of two layers, muscles and skin layers without closing of mucous layer. This practice will bring two problem. One, it will make bilateral labial fistula. premaxilla will be protected and lip will remain short.

So, the concentration of research work will be mainly on prelabium and mobilization of orbicularis muscles to brings all the abnormally attached tissue to the normal position and lengthen the lip to normal size. Disect the prelabium, which is always remain short. Design and cut the prelabium tissue and lengthen the short prelabium to normal length of the lip.



Fig.4.2 Before Surgery



Fig.4.3 After Surgery

No.2 My concentration will be on mucous layer which is most important for cleft surgery. Closer of mucous layer correctly and built up the sulcous layer with normal length is the foundation of cleft surgery.

This layer will avoid the labial fistula. Allow the normal development of maxilla and pre-maxilla, many cleft post-surgical complications arise due to surgeons fault, like labial or palatal fistula, deform nose, vermillion notch, short lip, scaring, velopharengial inefficiency, Fibrosis of pre-labium etc.

To correct all these post operation complication is difficult and the result never comes 100% satisfactory always. The result of 1st surgery is excellent if it is done correctly.

In many techniques, all these complications can be avoided and bring the excellent long term post-operative result with normal growth of lip-nose structures.





Fig.4.4 Before Surgery of a Complete Bilateral Cleft Lip

Fig.4.5 After Surgery of a Complete Bilateral Cleft Lip by Modified Millard Techniques



Fig.4.6 Before and After Surgery of a Complete Bilateral Cleft Lip by Modified Millard Techniques To save and respect 2-3 mm normal soft tissue that is mucous layer of prelabium can give long term excellent post-operative result without any scar at vermillion border which is very common in manchester technique.



Fig.4.7 Scar Formation of VermillionBorder by Manchester Techniques.



Chapter-V



5. RESULTS

In this study 75 patients/subjects were included to the hospital. Among the isolated patients/subjects, both male and female actively existed. According to Wikipedia cleft lip and palate occurs in about 1 to 2 per 1000 births in developed world. But there is no authentic data for male female ratio of cleft lip and palate. Among the respondents' majority of them (Group-A, 62% and Group-B, 64%) were male where (Group-A, 38% and Group-B, 36%) were female. Age group evaluation is very important for that current study. The table below (Table 5.1) reveals that among the respondents 29.33% were between 11 to 15 years of age where 22.67% were 6-10 years, 17.33% were 16-20 years and only 14.67% were between 3-5 years of age. The study area for the current study was mostly occupied by Muslim communities. So, among the respondents' majority (Group-A, 58% and Group-B, 52%) were Muslims, (Group-A, 30% and Group-B, 32%) were Hindus, (Group-A, 4% and Group-B, 0%) were Buddhist where (Group-A, 6% and Group-B, 24%) participants followed other religion. Occupation of parent may have an important role for occurring cleft lip and palate. Some industrial hazards should fetch under study. Majority (Group-A, 46% and Group-B, 48%) of the patients' mothers were occupied themselves as house wife and only (Group-A, 6% and Group-B, 24%) were worked as daily laborer. Whereas, majority (Group-A, 44% and Group-B, 28%) of the patients' fathers were occupied themselves as farmer, (Group-A, 32% and Group-B, 24%) were service holder, (Group-A, 14% and Group-B, 24%) were occupied with business and only (Group-A, 10% and Group-B, 24%) were worked as daily laborer. There are lots of evidence corroborated that History of cleft lip in maternal family played a certain role for cleft lip. Among the respondents (Group-A, 2% and Group-B, 32%) had family history of cleft lip and (Group-A, 98% and Group-B, 68%) had no previous history. In case of paternal family, the respondents (Group-A, 4% and Group-B, 20%) had family history of cleft lip and (Group-A, 96% and Group-B, 80%) had no previous history. Usually

bilateral cleft lip is a complex disorder which is persists with some other associated disorders. Among the respondents (Group-A, 28% and Group-B, 32%) had cleft palate, (Group-A, 24% and Group-B, 28%) had speech disorder, (Group-A, 22% and Group-B, 12%) had ear infection and (Group-A, 14% and Group-B, 8%) had alveolar cleft. It is a common phenomenon of the occurrence of the cleft on the both side of the lip along with cleft palate. In that research it happened frequently. Problems associated in food intake (Group-A, 42% and Group-B, 56%), (Group-A, 22% and Group-B, 20%) had problems in school going, (Group A, 16% and Group-B, 12%) had friendless and (Group-A, 0% and Group-B, 52%) had a marriage problems.

Demography	Gro	oup A	G	Froup B	P-value
	(3-15 ye	(3-15 years, n=50)		(> 15 years, n=25)	
	Numbers	Percentage	Numbers	Percentage	
Gender					
Male	31	62	16	64	0.322
Female	19	38	9	36	
Age					
3-5	11	14.67			0.526
6-10	17	22.67			
11-15	22	29.33			
16-20			13	17.33	
>20			12	16.0	
Religion of the	patient/subj	ect			
Muslim	29	58	13	52	0.711
Hindu	15	30	8	32	
Buddhist	2	4	0	0	
Others	4	8	4	16	
Occupation of p	patient`s/ m	other			
House wife	23	46	12	48	0.631
Service	15	30	3	12	
Business	9	18	4	16	
Daily laborer	3	6	6	24	

Table 5.1: Demography and Characteristics of Bilateral Cleft Lips (BCL)

Occupation of J	patient`s fat	her					
Farmer	22	44	7	28	0.261		
Service	16	32	6	24			
Business	7	14	6	24			
Daily laborer	5	10	6	24			
Birth order of t	the patient						
1 st	19	38	8	32	0.379		
2 nd	23	46	5	20			
3 rd	7	14	11	44			
4 th	1	2	1	4			
History of cleft	History of cleft lip in maternal family						
Present	1	2	8	32	0.177		
Absent	49	98	17	68			
History of cleft lip in paternal family							
Present	2	4	5	20	0.908		
Absent	48	96	20	80			
Associated physiological problem with bilateral cleft lip							
Cleft palate	14	28	8	32	0.163		
Alveolar cleft	7	14	2	8			
Ear infection	11	22	3	12			
Speech	12	24	7	28			
disorder							
None	6	12	5	20			
Associated social problem with bilateral cleft lip							
Food intake	21	42	14	56			
School	11	22	5	20			
Friendless	8	16	3	12			
Marriage	0	0	13	52]		

5.1. Types and Detection of Bilateral Cleft lip

In the modern era we are well equipped to diagnose cleft lip before the birth of the child. Now a days 4D ultrasound is available to find out these types of disorders. In our current study only 2.66% cases were diagnosed before birth by using ultrasound technique but majority (97.33%) were not diagnosed by ultrasound (Table 5.2 and Fig. 5.1). The cleft lip patents, were taken as sample of these study had some previous history of taking treatment from different orientation. 26.67% were getting spiritual treatment, 14.67% had experienced

homeopathic treatment and 4% were treated by barefoot doctors. Whereas, 54.67% did not experienced any treatment before.

The bilateral cleft lip is divided into two groups such as complete and incomplete. The pattern of cleft lip which extends to the nose is termed as complete and that does not extend to the nose is termed as incomplete. In the current study 57.33% cases were complete where 42.67% cases were incomplete type of cleft lip. It is a very common of presence of cleft palate with the bilateral cleft lip. In that research it also happened frequently. We found associated cleft palate with bilateral cleft lip in 29.36% cases. But in case of majority (70.67%), did not find any association of the bilateral cleft lip along with cleft palate.

	Numbers of CBL (n=75)	Percentage	P-value		
Diagnosis of cleft lip	Diagnosis of cleft lip before birth by ultrasound				
Diagnosed	2	2.66	0.546		
Not diagnosed	73	97.33			
Treatment taken for cleft lip before surgical intervention					
Spiritual treatment	20	26.67			
Homeopathic	11	14.67	0.317		
By village doctor	03	4.0			
No treatment taken	41	54.67			
Nature of cleft lip					
Complete	43	57.33	0.853		
Incomplete	32	42.67			
Associated palatal cleft					
Present	22	29.36	0.637		
Absent	53	70.67			

Table 5.2: Types and Detection of Bilateral Cleft lip of the studysubjects.


Fig.5.1: Bar Diagram showing Bilateral Cleft lip of the study subjects.

5.2. Lip Structure of Bilateral Cleft lip Subjects Before surgery

Pre-operative lip length measurement was very essential for that study. The lip length was measured by the summation of the length (mm) of lip angle of one side of the Cupid's bow, the width of cupid's bow and the length of Cupid's bow to the angle of another side of lip. In this study, 43 cases of complete bilateral cleft lip where in 3-5 years patients the average lip length was 67 mm, 6-10 years patients the average lip length was 76mm, in 11-15 years patients the average lip length was 79mm, in 16-20 years patients the average lip length was 83mm before the surgical intervention (Table 5.3 and Fig. 5.2).

On the other hand 32 cases of incomplete bilateral cleft lip where in 3-5 years patients the average lip length was 63 mm, 6-10 years patients the average lip length was 66 mm, in 11-15 years patients the average lip length was 68 mm, in 16-20 years patients the average lip length was 73 mm and in case patients of more than 20 years the average lip length was 75 mm before the surgical

intervention. Correction of lip height is mandatory for bilateral cleft lip surgery. For this reason, it was essential to measure the pre-operative lip height of the bilateral cleft lip subjects. Then measured the lip height by measuring the distance of collumella to cupid's bow of different aged patients. In that study, 43 cases of complete bilateral cleft lip patients and 32 cases of incomplete bilateral cleft lip patients before the surgical intervention.

Lip width/thickness of bilateral cleft lip patients pre-operatively was compulsory. According to the measurement we categorized the group as Normal, Too thick, Too thin. In the current study, 43 cases of bilateral complete cleft lip and 32 cases of bilateral incomplete cleft lip patients of different ages. The system of measuring nostril width by summation of alar base of one side to columella, columella width and columella to alar base of another side. In the existing study we measured the nostril width of 75 cases of different aged group patients. In the 3-5 years aged group the average nostril width was 39 mm, In the 11-15 years aged group the average nostril width was 44 mm, In the 16-20 years aged group the average nostril width of 49 mm before the surgical intervention.

Lip Measurements		Age gro	Age groups (Years)		
(mm)		Group-A	Group-B		
	CBL Type	3-15	16>20	P-value	
		n=50	n=25		
Average lip length	complete	32%	11%	0.0001***	
	incomplete	20%	12%	0.0001***	
Average lip height	complete	32%	11%	0.747	
	Incomplete	20%	12%	0.563	
Average lip	complete	32%	11%	0.899	
width/thickness	incomplete	20%	12%	0.952	
Average nostril		52%	23%	0.0001***	
width					

 Table 5.3: Nature of Bilateral Cleft lip Subjects Before surgery

***very highly significant



Fig.5.2: Bar Diagram showing Lip Structure of Bilateral Cleft lip Subjects Before surgery

5.3. Length and Size of Lip-Nose Measurements of Bilateral Cleft lip Subjects Before surgery

In this study, different forms of columella condition were found. Among them 24% were normal, 57.33% were short, 13.34% were wide base and 5.33% were narrow base.

The nasal septum also may have changed due to bilateral cleft lip condition. Vermilion border is an important component for treating the cleft lip patients. In bilateral cleft lip patients, the vermilion border might be normal, notched or deformed. In the existing study, 43 cases of bilateral complete cleft lip patients, where 18.60% had normal vermilion border, 76.75% had notched vermilion border and 4.65% had deformed vermilion border before the surgical intervention and 32 cases of bilateral incomplete cleft lip patients, where 18.75% had normal vermilion border, 75% had notched vermilion border and 6.25% had deformed vermilion border the surgical intervention border before the surgical intervention.

Cupid's bow plays an important role for lip formation. Pre-operatively we observed three kinds of Cupid's bow like normal, narrow and wide. In the group

of complete bilateral cleft lip patients were 43 and incomplete bilateral cleft lip patients were 32 cases.

The philtrum area above the upper lip is often deformed due to cleft lip occurrence. In the current study we got 43 cases of complete bilateral cleft lip patients. Among them 11.62% had normal philtrum where 88.38% had short philtrum before the surgical intervention and 32 cases of incomplete bilateral cleft lip patients. Among them 12.5% had normal philtrum, 9.38% had narrow philtrum, 6.25% had wide philtrum where 88.38% had short philtrum (Table 5.4 and Fig. 5.3 to 5.6).

Table 5.4: Length and Size of Lip-Nose Structures of Bilateral Cleftlip Subjects Before surgery

Length and Size of	CBL Type	Subjects	Frequenc	Percentage	P-value
Lip-Nose (mm)			У		
		Normal	18	24.0	
		Short	43	57.33	0.0001
Columella		Wide base	10	13.34	***
		Narrow base	4	5.33	
Nasal septum		Normal	30	40	0.701
		Deviated	45	60	0.701
Condition	complete	Normal	8	18.60	
vermilion border		Notched	33	76.75	0.470
		Deformed	2	4.65	
	incomplete	Normal	6	18.75	
		Notched	24	75.0	0.845
		Deformed	2	6.25	
Condition of	complete	Normal	6	13.95	
Cupid`s bow		Narrow	4	9.30	0.298
		Wide	33	76.75	
	incomplete	Normal	5	15.62	
		Narrow	3	9.38	0.023
		Wide	24	75.0	
Condition of	complete	Normal	5	11.62	
Philtrum		Narrow	0	0	0.464
		Wide	0	0	0.404
		Short	38	88.38	
	incomplete	Normal	4	125	
		Narrow	3	9.38	0.611
		Wide	2	6.25	0.011
		Short	23	71.87	

***very highly significant



Fig.5.3: Length and Size of Lip-Nose Structures of Bilateral Cleft lip Subjects Before surgery.



Fig.5.4: Bar-Diagram Showing Condition Vermilion Border of Bilateral Cleft Lip Subjects before Surgery



Fig.5.5: Bar-Diagram Showing Condition of Cupid'S Bow of Bilateral Cleft Lip Subjects before Surgery



Fig.5.6: Bar-Diagram Showing Condition of Philtrum of Bilateral Cleft Lip Subjects before Surgery

5.4. Lip-Nose Correction of Bilateral Cleft Lip after Surgery

The table reveals a comparison representation of before and after the average lip length of complete bilateral cleft lip patients. In the 3-5 years patients the average lip length before surgery was 67 mm and after 3 month of surgery it was 51mm where after 6 month it became 50.5 mm. In the 6-10 years patients, the average lip length before surgery was 76 mm and after 3 month of surgery it was 57mm where after 6 month it became 56.5 mm. In the 11-15 years patients the average lip length before surgery was 79 mm and after 3 month of surgery it was 63mm where after 6 month it became 62.5mm, In the 16-20 years patients the average lip length before surgery was 77 mm and after 3 month of surgery it was 63mm where after 6 month it became 69.6 mm and patients of more than 20 years, the average lip length before surgery was 83 mm and after 3 month of surgery it was 76 mm where it became 75.5 mm after 6 month of surgical intervention.

In case of incomplete bilateral cleft lip patients, 3-5 years patients the average lip length before surgery was 63 mm and after 3 month of surgery it was 57 mm where after 6 month it became 56.5 mm, In the 6-10 years patients the average lip length before surgery was 66 mm and after 3 month of surgery it was 59 mm where after 6 month it became 58 mm, In the 11-15 years patients the average lip length before surgery was 68 mm and after 3 month of surgery it was 63 mm where after 6 month it became 63 mm, In the 16-20 years patients the average lip length before surgery was 73 mm and after 3 month of surgery it was 70mm where after 6 month it became 70 mm and patients of more than 20 years, the average lip length before surgery was 75mm and after 3 month of surgery it was 71mm where it became 71 mm after 6 month of surgical intervention.

This table discloses association of before and after the average lip height of complete bilateral cleft lip patients and incomplete bilateral cleft lip patients.

After surgical intervention of complete bilateral cleft lip patients (43 cases), the lip width/thickness in certain interval. In the 3-5 years aged group patients the

average lip width was normal in 91.67% cases and 8.33% cases showed too thick lip thickness. In the 6-10 years aged group patients the average lip thickness after the surgery was normal in 81.82% cases, 9.09% cases showed too thin and 9.09% showed too thick lip width. In the 11-15 years aged group patients the average lip width after surgery was normal in 88.89% cases. In the 16-20 years aged group patients the average lip thickness after the surgery was normal in 85.72% cases and the patient group of more than 20 years age, the average lip width after the surgery was normal in 100% cases.

In case of incomplete bilateral cleft lip patients (32 cases), the lip width/thickness in certain interval. In the 3-5 years aged group patients the average lip width was normal in 75% cases and 12.5% cases showed too thick lip thickness. In the 6-10 years aged group patients the average lip thickness after the surgery was normal in 85.72% cases, 14.28% cases showed too thick. In the 11-15 years aged group patients the average lip width after surgery was normal in 100% cases. In the 16-20 years aged group patients the average lip thickness after the surgery was normal in 88.89% cases and the patient group of more than 20 years age, the average lip width after the surgery was normal in 100% cases. This table also reveals the average nostril width of bilateral cleft lip patients, before and 6 month after surgical intervention (Table 5.5 and Fig. 5.7 to 5.13).

			Folloup		Age groups (Years) F				P-value
Lip-		D.f	Period		Group-	A	Grou	p-B	
Nostril Type		Before/			3-15		16>20		
Correctios		Alter		3-5	6-10 Y	11-15	16-20	>20	
				Y		Y	Y	Y	
		before		67	76	79	77	83	0.0001***
	complete		3 month	51	57	63	70	76	
		after	6 month	50.	56.5	62.5	69.6	75.5	0.0001***
Average				5					
lip length		before		63	66	68	73	75	0.001***
(mm)	incomplete		3 month	57	59	63	70	71	
	meompiete	after	6 month	56.	58	63	70	71	0.001***
		arter		5					
		1.6		24	25	21	22	22	
		before	2 4	24	25	31	32	32	0.0001***
	complete	C.	3 month	23	24	28	29	31	
Average		after	6 month	22.	23.5	27.5	29	30.5	0.0001***
lip height				<u> </u>	20		2.5		
(mm)		before		28	28	33	35	37	0.0001***
	incomplete	0	3 month	24	25	28	29	31	
	··· 1····	after	6 month	23.	24.5	28	28.5	30.5	0.0001***
			N 7 N	5	0				
			Normal	9	8	6	4	2	-
		before	Тоо	2	2	2	2	1	
			thick						-
	complete		Too thin	1	1	1	l	I	0.369
		6 month	Normal		9	8	6	4	-
		after	100	1	1	I	I	0	
Average			thick	0		0	0		-
lip			Too thin	0	1	0	0	0	
thickness			Normal	5	4	3	6	2	-
(mm)			100	2	2	I	2	I	
()		before	thick	1	1	1	1	0	
			Too thin	1	1	I	I	0	
	incomplete								-
		6 month	Normal	6	6	5	8	3	0.547
		after	Тоо	1	1	0	1	0	0.347
			thick						4
			Too thin	1	0	0	0	0	
Average		before		35	39	44	46	49	4
nostril		6 month		28	32	35	39	43	
width		after							0.0001***
(mm)								1	1

Table 5.5: Comparison of Lip-Nostril Corrections of Bilateral CleftLip before and after Surgery.

***very highly significant



Fig.5.7: Line-Diagram Showing Average Lip Width/Thickness of Bilateral Cleft Lip after Surgery



Fig.5.8: Bar-Diagram Showing Average Lip Length of Bilateral Cleft Lip after Surgery



Fig.5.9: Bar-Diagram Showing Average Lip Height of Bilateral Cleft Lip after Surgery



Fig.5.10: Bar-Diagram Showing Average Nostril Width of Bilateral Cleft Lip after Surgery



Before





Fig.5.11: Bilateral Cleft Lip and Palate Repair by Modified Millard's Techniques.



Fig.5.12: Facial Cleft (Bilateral Cleft) repair by Modified Millard's techniques.



Fig.5.13: Lip-Nose Structures (Bilateral Cleft) repair by Modified Millard's techniques.

5.5. Length and Size of Lip-Nose Structures of Bilateral Cleft lip Subjects Before and After Surgery

In the current study, different forms of columella condition were seen. Among them 24% were normal, 57.33% were short, 13.34% were wide base and 5.33% were narrow base before surgery and after surgery 80% were normal and 20% were short.

The nasal septum also may have changed due to bilateral cleft lip condition. In the current study, 40% of normal nasal septum where 60% of them get deviated before the surgical intervention and after surgical intervention 97.33% normal, 2.67% deviated.

Vermilion border is a significant component for the cleft lip deformities patient. In bilateral complete cleft lip patients/subjects, the vermilion border might be normal, notched or deformed. In the existing study, before and after the surgical intervention, normal percentages of vermilion border were increased. In bilateral incomplete cleft lip patients, before and after the surgical intervention, normal percentages of vermilion border were increased.

Cupid's bow plays an important role for lip formation. Pre-operatively we saw three types of Cupid's bow such as normal, narrow and wide. 43 cases were found in the group of complete bilateral cleft lip patients and 32 cases in incomplete bilateral cleft lip patients.

The philtrum area above the upper lip is often deformed due to cleft lip occurrence. In the current study, 43 cases of complete bilateral cleft lip patients and 32 cases of incomplete bilateral cleft lip patients. Among them, before and after the surgical intervention normal philtrum were increased from 11.62% to 95.35% Table 5.6 and Fig. 5.14 to 5.18).

		Comparison					р-
Lip-Nose Structures		Type Before surgery		6 months after surgery		value	
			Frequency	%	Frequency	%	
		Normal	18	24.0	60	80.0	0.635
Columelle		Short	43	57.33	15	20.0	
Columella		Wide base	10	13.34	0	0	
		Narrow base	4	5.33	0	0	
Nasal		Normal	30	40	73	97.33	0.248
septum		Deviated	45	60	2	2.67	
	Complete	Normal	8	18.60	36	83.72	0.092
		Notched	33	76.75	6	13.96	
Vermilion		Deformed	2	4.65	1	2.32	
Border	Incomplete	Normal	6	18.75	28	87.5	0.240
		Notched	24	75.0	3	9.37	
		Deformed	2	6.25	1	3.13	
	Complete	Normal	6	13.95	40	93.02	0.001
		Narrow	4	9.30	1	2.33	
Cupid`s		Wide	33	76.75	2	4.65	
bow	Incomplete	Normal	5	15.62	29	90.63	0.055
		Narrow	3	9.38	2	6.25	
		Wide	24	75.0	1	3.12	
	Complete	Normal	5	11.62	41	95.35	0.885
		Narrow	0	0	2	4.65	
		Wide	0	0	0	0	
Philtrum		Short	38	88.38	0	0	
1 IIIII uiii	Incomplete	Normal	4	12.5	27	84.38	0.233
		Narrow	3	9.38	4	12.5	
		Wide	2	6.25	1	3.12	
		Short	23	71.87	0	0	

Table 5.6: Follow up of Length and Size of Lip-Nose Structures ofBilateral Cleft lip Subjects Before and After Surgery



Fig.5.14: Bar-Diagram Showing Vermilion Border Bilateral Cleft lip Subjects Before and After Surgery



Fig.5.15: Bar-Diagram Showing Cupid'S Bow Bilateral Cleft Lip Subjects Before and After Surgery



Fig.5.16: Bar-Diagram Showing Philtrum Bilateral Cleft Lip Subjects Before and After Surgery



Before

After

Fig.5.17: Nasal Cleft Repair by Modified Millard's Techniques.



Fig.5.18: Length and Size of Lip-Nose Structures of Bilateral Cleft Lip Subjects Before and After Surgery by Modified Millard's Techniques.

5.6. Post-Surgical Scaring and Bilateral Cleft Lip Repair

Scar mark formation after surgical intervention is a common phenomenon. In the current study we were remarkably cognizant to avoid poor scar mark. And at the end of the study we found 86.67% scar mark which were aesthetic, 13.33% scar mark were satisfactory and poor scar mark were (Fig. 5.19 to 5.20).

Scar mark after surgery	Frequency	%	P-value
Aesthetic	65	86.67	
Satisfactory	10	13.33	0.771
Poor	0	0	0.771
Total	75	100	



Fig.5.19: Pie-Chart Showing Post-Surgical Scar Mark After Surgery



Bilateral Cle	ft Lip	Bilateral Cleft Palate
	Before	



Repair of Bilateral Cleft Lip and Palate

After

Fig.5.20: Post-Surgical Repair of Bilateral Cleft Lip and Palate.

Chapter-VI

DISCUSSION

6. DISCUSSION:

In bilateral cleft lip deformity, the anatomic characteristic is shown separately dependent on the level of the early embryological miscarriage and on the level of anomalous development after delivery (Veau *et al.* 1936). Although, it was well-known that maximum success might be achieved by identifying the level of fetal miscarriage through the precise pre-surgical assessment. The anatomic malformation of the cleft on the both side of the lip (complete cleft lip) was inclined by the abnormal tissue developed from the mesoderm, such as skeleton and muscles, and, later it has the mechanism similar to the anatomic malformation of unilateral cleft lip. The nasal septum and nasal bone are situated straight without deviation in case of nasal abnormality (CBL). However, if the periodontal tissue was adhered to any side or if a Simonart band was present, it could show a shape related to CSL (Cleft on the one side of the lip). In case of alar cartilage deformity, bilateral cleft lip displays arrangement related to CSL, but the flaring and buckling of the lateral angle of the nasal cartilage seem to be more austere. (McComb. 1975)

In CBL, columella tends to be short because the alar cartilage is spreading extensively. Present of fibrous adipose tissues between the nasal tip and the alar cartilage excessively, developing the blunt nasal tip. (Potter. 1968; Steinstrom and Oberg. 1961), complete CBL is developed embryo-logically by the failure of the mesodermal reinforcement of both maxillary procedures, and the migration of nasofrontal procedure appears to be normal. In incomplete CBL, muscular fibers are detected in the prolabium, which suggests the partial migration of muscles.

In bilateral cleft lip, the morphologic characteristic are determining by some intrinsic and extrinsic factors. (Mulliken. 1992) The intrinsic factors are wide and columella short, nasal tip bifid with a horizontally oriented nostril axis. The alar cartilage shows hypoplasia. It is also caudally rotated, and subluxated from the upper lateral cartilage. The genu is extended and the tissue of the alar margin

is hypo-plastic. These intrinsic elements result in primary abnormality. The extrinsic factors are the secondary changes which coming from the complete bilateral cleft lip repair. If the deformity is corrected by the conventional methods, the medial crus of the alar cartilage are pulled infero-posteriorly which make the columella shorter. If the lateral labial segment is absorbed without shortening, despite the fact that the vertical length of the lateral labial segment is long, the alar and the lateral crus of the alar cartilage will be cephalad displaced. As a result, the alar dome will get arched, and the space between the genu will get broader, causing relocate of the malformation more problematic in later times.

Several methods have been introduced to the repair of BCL, with their own advantages and deficiencies. In BCL repair, most researchers suspended the time of modification of nasal malformation and focused on the system of expansion the columella. There are 2 types of methods which bring tissues to the columella. Number one, bring the tissues from the upper lip, which is the fork flap method defined by Millard. (Millard. 1958) The other technique is demonstrated by Cronin. The method in which, the nasal dorsum, alar margin, and nasal floor tissues brings to the columella (Cronin. 1958). Such techniques leave a scar mark through the columella-labial connection, and the scar surrounds the prolabium, and thus, the prolabium becomes obtruded rather than depressed. Besides, Millard's techniques, the columella-labial position may be acute, more severe by the accompanied scar (Mulliken.1995).

So, the disadvantages of other techniques of bilateral cleft surgical cases if we study this picture in Tennison techniques for example.



Fig. 6.1. Advantages of Modified Millard techniques over Tennison techniques.

In this picture the defects are:

1. There is no continuity of orbicularis oris muscle with pre-maxilla as a result there are bilateral hypertropy of oris muscle of upper lip.

2. There are bilateral vermillion notch

3. There are bilateral defect of nasal floor

4. There is shortness of upper lip mainly the premaxillary area, which make the extra work of lower lip at the end even the lower lip has hypertropy.

- 5. Widening of filtral ridge
- 6. Scar formation on the skin

Because of discontinuity of oris muscle which pull the premaxilla, hamper the normal growth of premaxilla results the shortness of upper lip.



Fig. 6.2: Advantages of Modified Millard techniques over Manchester techniques

In manchester techniques, Normally the incision was given at vermillion border of premaxilla. The normal mucous layer of premaxilla discard in this techniques. As a result long term surgical outcome is not aesthetic because of there is abnormal scar formation at cupid bow area.



Fig. 6.3: Abnormal scar formation at cupid bow area



In this study techniques, save this mucous layer of premaxilla.

Fig. 6.4: Modified Millard techniques

To save this 2-3 mm of normal tissue (mucous membrane of premaxilla) gives an excellent long term aesthetic result.

Dissection of premaxilla:

Many surgeons believe and practice not to dissect the premaxilla. It is believed that, if dissect premaxilla it could be necrossed. In many years Bilateral cleft surgical practice always disect the premaxilla with resasons:

a) If it is disect, it can lengthen the premaxillary tissue which is always short.

b) After lengthening it is very easy to lengthen the lip up to the satisfactory normal lip length.

c) If it is disect then another big advantage, it can close the mucous layer without any chance of post-surgical formation of labial fistula (which is another very common post-operative complication of Bilateral cleft surgery)



d) With this mucous closure it can built very good length of sulcous formation, which will give you long term normal growth of premaxilla.



Fig.6.6: Modified Millard techniques

These are very important points of dissecting premaxilla.

Muscular dissection and rotation:

In this study techniques (modified millard techniques), separate the oris muscles from abnormal attachment. area and rotate that muscles, then bring the peripheral and central fibers of orbicularis muscles criss cross over dissected premaxilla that gives –

- 1) Continuity of oris muscles
- 2) Helps to build up the floor of nose.
- 3) Give good length of upper lip

In long terms it gives a very good post-surgical aesthetic outcome.

So, in this techniques, can avoid unnecessary post-surgical complication which was dissect before in tennison and Manchester techniques.

We can avoid scar formation at cupid bow area which is very common in Manchester techniques.

In this techniques can avoid discontinuity of oris muscles and inadequate development of premaxilla in Tennison techniques which results the shortness of upper lip.

Some surgeons criticize about millard post-operative technique regarding decreasing total lip length. This shrinkage depends upon the dissection and proper rotation of abnormally attached oris muscles fibres.

If somebody can dissect and rotate the abnormal oris muscles fibers (including peripharalis and centralis fibres) and bring all those muscles in normal position with normal length of the lip in that condition there will be no significant postoperative contractions of lip length.

This dissection, separation of abnormal attachment and rotation of oris muscles will help to bring equal level of protected premaxilla of Bilateral cleft cases.

No other technique like premaxillary osteotomy needed to bring the protected premaxilla down. Once, release the oris muscles gently or nicely and rotate it automatically everything will be equal level.

Disadvantage of premaxillary osteotomy never reunite the fracture bone of premaxilla always it remain unstable. So it is better not to do any premaxillary osteotomy.

There is some quality needed for the bilateral cleft surgery. So, Quality of a Surgeon in cleft surgery are-

1. A surgeon need to dedicate his professional time and practice to do a perfect surgery because many post-operative cleft surgical complication arise due to surgeons fault.

2. No surgeon should compromise with above all these important factors to get a good satisfactory aesthetic surgical outcome.

Different treatment procedures (pre-operative and post-operative orthodontic treatment, different age of the patient's at the time of the surgery, different methods of surgery) might affect post-operative outcomes. In CBL, operations in different cleft centers were implemented at the different age of the patient's varying from 3 years to more than 20 year, mostly from 11 to 15 years (29.33%). In the current research, all operations were completed at the Cleft Center, and only the skilled physicians operated the patients using the same treatment protocol (modified Millard method). Therefore, these factors gave the improved possibility to compare different operational procedures eliminating the influence of different treatment protocols, patient's age at the time of operation, and specialists' knowledge on the postoperative outcomes. Up to now, numerous procedures of the evaluation of cleft lip plasty have been suggested.

According to the Tennison procedure, even very wide clefts are succeeded by single surgery (Chowdri *et al.* 1990). In the present study, patients were divided

into two separate subgroups, such as group-A (3 to 15 years) and group-B (15 to >20 years).

Although, the impact of cleft width on esthetic results were very much possible to estimate. The cleft lip patents, were taken as sample of these study had some previous history of taking treatment from different orientation. 26.67% were getting spiritual treatment, 14.67% had experienced homeopathic treatment and 4% were treated by village doctors. Whereas 54.67% did not experienced any treatment before. In our current study only 2.66% cases were diagnosed before birth by using ultrasound technique.

The ultimate aims in cleft lip operation are evading of nasal abnormalities (Numa *et al.* 2006). There are few data that the Millard system gave better outcomes in the formation of the nostrils than the Tennison method (fig.6.1) (Tan and Atik. 2007). It might be concluded that millard method has advantages but none of the other techniques showed considerably better outcomes in the development of the nostrils. In primary cleft lip plasty, it would be sensible to isolate such components as lip and nose. CBL repair straightly do not include rhinoplasty, but during primary cheiloplasty, new nostrils are formed, and the connection of the nasal cartilages is also transformed. There is ongoing discussion at what place skin incision in nostril area must be done to mobilize the alar cartilage during primary cleft lip plasty or it must be done during secondary surgery, how and where with to fix mobilized cartilages, to use or not to use postoperative stents (Nagy and Mommaerts. 2007).

The aims of Bilateral Cleft lip repair contain the construction of a complete upper lip with suitable perpendicular length and symmetry, restoration of the underlying muscular structures to succeed regular function, and the managing of the related nasal abnormality. The Tennison–Randall and Millard's rotational advancement flap procedure rests the most recognized systems. With the need of time and situation, definite changes in both procedures are made and combinations of both have been utilized. But in this research modified Millard's techniques is far better than Tennison techniques (fig.6.1).

The studies by Linas Zaleckas *et al* (Zaleckas *et al*. 2011) and Tomohiro Yamada *et al* (Yamada *et al*.2002) where in, they detected better symmetry of the Cupid's bow been restored by use of Tennison's method but in this study (modified Millard's) the findings are far better than the reported study.

Therefore, the current research suggested that modified Millard's technique gave better outcomes with respect to white roll match, alar base symmetry, Cupid's bow symmetry and the lip length. Conversely, in case of post-operative, the incisional scars on patients treated with Modified Millard's procedure was considerably better than those patients treated using Tennison- Randall technique.

In Manchester techniques, a small prolabium raises ample size after operation. Secondary malformations such as miserable nose, tiny columella and widespread cupid's bow persisted to be resolved in some cases even by the Manchester repair. Secondary repair of a very depressed nose and small columella is implemented at the age of 4-6 years. In such cases, modified Millard's techniques on the upper lip and extended the short columella, while at the same time repairing the widespread cupid's bow. (fig.6.2)

Chapter-VII

Recommendation

7. RECOMMENDATION:

In Modified Millard techniques can avoid discontinuity of or is muscles and inadequate development of premaxilla but in Tennison techniques which results the shortness of the upper lip.

Factors for the recommendation of that aesthetic surgical outcome are-

- 1. Skilled and Trained surgeon
- 2. Fine quality of instruments
- 3. Quality suture materials with different size.
- 4. Use of different size suture materials in different layers of cleft surgery.
- 5. Size and sharpness of needles use for cleft surgery
- 6. Tightening of knot especially at for prevention of post-operative scar formation.
- 7. Distance of suture from incision line is important for prevention of scar formation.
- 8. Handling of skin layer by instrument such as tooth adson forcep can cause micro scar formation.
- 9. Government and Non-government relation should build up.
- 10. Our government should proper steps for the involvement of the international NGOs.
- 11. Further study on this field can be possible.
- 12. Arrange frequently international cleft seminar.


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APPENDICES

APPENDICES

APPENDIX-I

The goals of treatment for the child with a clef lip/ palate are:

- Repair the birth defect (lip, palate, nose)
- Achieve normal speech, language and hearing
- Achieve functional dental occlusion and good dental health
- Optimize psychosocial and developmental outcomes
- Minimize costs of treatment
- Facilitate ethically sound, family-centered, culturally sensitive care

APPENDIX-II

Seven key themes are important for achieving these goals:

- Early assessment and intervention is imperative and should begin in the newborn period with referral to a Clef Lip/Palate Team. When clef lip/palate is diagnosed prenatally referral to a team should be offered.
- An interdisciplinary clef lip/palate team is needed because clef lip/palate outcomes are in surgical, speech, hearing, dental, psychosocial and cognitive domains.
- Providers with training and expertise in clef lip/ palate care are needed because of the complexity of treatment interventions.
- Continuity of care is essential because outcomes are measured throughout the child's life and team care is linked to improved outcomes.
- Proper timing of interventions is critical because of the interaction of facial growth, dental occlusion and speech.

• Coordination of care is necessary because of the complexity of the medical, surgical, dental and social factors that must be considered in treatment decisions.

• Better early management leads to better outcomes, fewer surgeries and lower costs.

APPENDIX-III

Overview: Summary of Key Interventions by Age

Note: Tis table is only a *summary* and does not contain every intervention that could be needed by a particular child at a certain age. For more details see pages referenced.

Age Range	Intervention
Prenatal	Refer to clef lip/palate team
	Medical diagnosis and genetic counseling
	Address psychosocial issues
	Provide feeding instructions
	• Make feeding plan
Birth-1 month	• Refer to clef lip/palate team
	• Medical diagnosis and genetic counseling
	 Address psychosocial issues
	• Provide feeding instructions and monitor growth
	• Begin presurgical orthopedics if indicated
1-4 months	Monitor feeding and growth
	Repair clef lip
	Monitor ears and hearing
	• Begin/continue presurgical orthopedics if indicated
5-15 months	Monitor feeding, growth, development
	• Monitor ears and hearing; consider ear tube
	Repair clef palate

	Instruct parents in oral hygiene
16-24 months	Assess ears and hearing
	Assess speech-language
	Monitor development
2-5 years	Assess speech-language; manage VPI*
	Monitor ears and hearing
	Consider lip/nose revision before school
	Assess development and psychosocial adjustment
6-11 years	Assess speech-language; manage VPI
	Orthodontic interventions
	Alveolar bone graft
	Assess school/psychosocial adjustment
12-21 years	Jaw surgery, rhinoplasty (as needed)
	• Orthodontics; bridges, implants as needed
	Genetic counseling
	Assess school/psychosocial adjustment

*VPI = velopharyngeal insufciency.