Age 1–7 years early years care follow-up

Age 1–7 years: early years care/ follow-up

Following primary surgery , regular review by an MDT is essential. Many aspects of cleft care require review during the early years of childhood: /uni25CF hearing; /uni25CF speech; /uni25CF dental development; /uni25CF wound healing and aesthetics. Hearing Eustachian tube dysfunction plays a central role in the patho -). genesis of otitis media with e ff usion (OME) in babies and children born with a cleft palate. Children with a cleft lip alone exhibit the same frequency of otitis media as their age-matched counterparts, whereas those c hildren with palatal involvement may have an increased incidence of OME. Regardless of the hearing is within normal limits. All children are screened at birth, but those who have a cleft palate are monitored regularly with audiological screening. Speech In the UK, specialist SLTs involved in cleft care engage at an early stage with families and children. Some teams will run group sessions to encourage speech development. Speech is constantly monitored during development and early interven tion is advisable if speech pathology is suspected or diagnosed. The problems that may present can be considered in two broad groups: 1 Velopharyngeal incompetence (VPI). Where the soft palate fails to achieve adequate velopharyngeal clo sure, which is required for certain sounds in speech, air escape occurs, leading to the resonance issue of hyper nasality . This can lead to unintelligible speech because of either the hypernasality itself or the adaptations made by the child in an attempt to achieve velopharyngeal closure. 2 Articulation errors . These either arise as a compen satory mechanism, as stated above to overcome VPI, or, less commonly , are caused by jaw/dental and occlusal abnormalities. To investigate these problems, the cleft team relies upon the specialist SLT assessment and investigations such as lateral videofluoroscopy and nasendoscopy . These investigations ar used to visualise the palate as it moves in real time during speech. Secondary speech surgery may be o ff ered when there are structural issues to overcome such as VPI. Cleft palate repair is carried out when the palatal function is assessed to be sub optimal but other procedures that alter the dynamics of airflow during speech to reduce nasal escape may also be employed. These interventions are broadly termed pharyngoplasty procedur es. Dental Dental anomalies are common findings in children with cleft lip and/or palate. Various phenomena, including delayed tooth development, delayed eruption of teeth and morpho logical abnormalities, are well documented. The number of teeth may be reduced (hypodontia) or increased (hyperdontia), occurring most commonly in the region of the cleft alveolus and involving the maxillary lateral incisor tooth. These abnor malities can occur in both primary and secondary dentition. All children with cleft lip and palate should undergo regular dental examination. Dental management should also include preventive measures such as dietary advice, fluoride supple ments and fissur e sealants. A well-maintained and disease-free dentition in childhood provides the optimal situation for successful orthodontic treatment. Wound healing/aesthetics Wound infections are rare but if they occur may lead to revi sion surgery . If this is a lip wound infection then revision

can be timed to be pre-school or, if the problem is subtle, the lip can be revised opportunistically at the time of, for example, ABG. ryngoplasty as described earlier in Speech .

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