

# Cleft Projects

## Synergies of Ideas

**Prof. Dr. Dr. Srinivas Gosla Reddy**

FACS, FRCS, FDSRCS (Eng, Edin), PhD, MBBS, MDS

**Dr. Rajgopal R. Reddy**

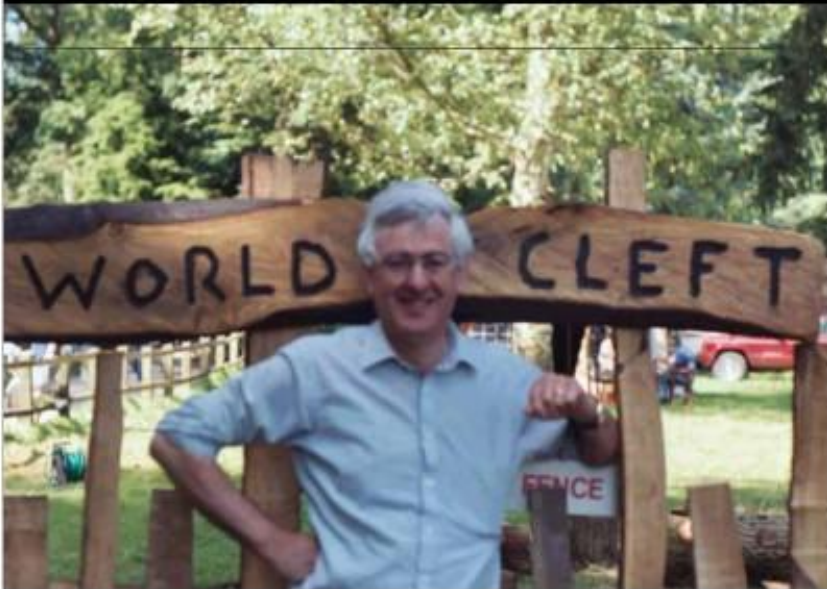
MBBS, BDS, FDS RCS (Glasg)





“Everyone needs a unique face for his identity”

**Prof. Dr. Hermann F. Sailer, President, Cleft Children International**



“The cost of sickness and the price of health has shown that poverty and disease form a vicious circle. People are sick because they are poor and poorer because they are sick and sicker because they are poorer.”

**Mr. A. F. Markus, Consultant, Dorset Cleft Center, Poole, United Kingdom**



## Developing and Standardizing a Center to Treat Cleft and Craniofacial Anomalies in a Developing Country Like India

Srinivas Gosla Reddy, MDS, MBBS,\* Likith V. Reddy, DDS, MD, FACS,†  
and Rajgopal R. Reddy, BDS, MBBS\*

**Abstract:** The range of facial deformities is enormous. All produce some degree of disfigurement and result in the impairment of function to some degree, sometimes even to the point of incompatibility with life. Congenital facial defects in India are associated with considerable superstition, social rejection, and failure to integrate into society.

In India, cleft defects occur in 1 in 500 births. Congenital facial defects are a pressing problem in India owing to the limited resources to treat such patients. Poverty is a major factor for parents of such children to get appropriate treatment.

Setting up an institute to treat children with cleft and craniofacial deformities in India presents problems with financing treatment for poor patients, procuring the right infrastructure, and employing well-trained human resources.

The authors have set up such an institute in Hyderabad in the southern state of Andhra Pradesh in India. The logistics of setting up such a facility in a developing country and the future of funding for cleft treatment are important factors to consider while establishing a center for patients with cleft and craniofacial anomalies.

The aim of setting up such centers was to provide quality comprehensive treatment for patients from all sections of society with cleft and craniofacial anomalies.

**Key Words:** Cleft lip, cleft palate, craniofacial anomalies, developing and standardizing, institute, cleft surgery, speech therapy, orthodontics

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The range of facial deformities is enormous. All produce some degree of disfigurement and result in the impairment of function to some degree, sometimes even to the point of incompatibility with

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Developing and Standardizing a Center to Treat Cleft and Craniofacial Anomalies in a developing Country Like India

Journal of Craniofacial Surgery, 20(8):1664-1667, September 2009.



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# WHY CREATE?

## INDIA

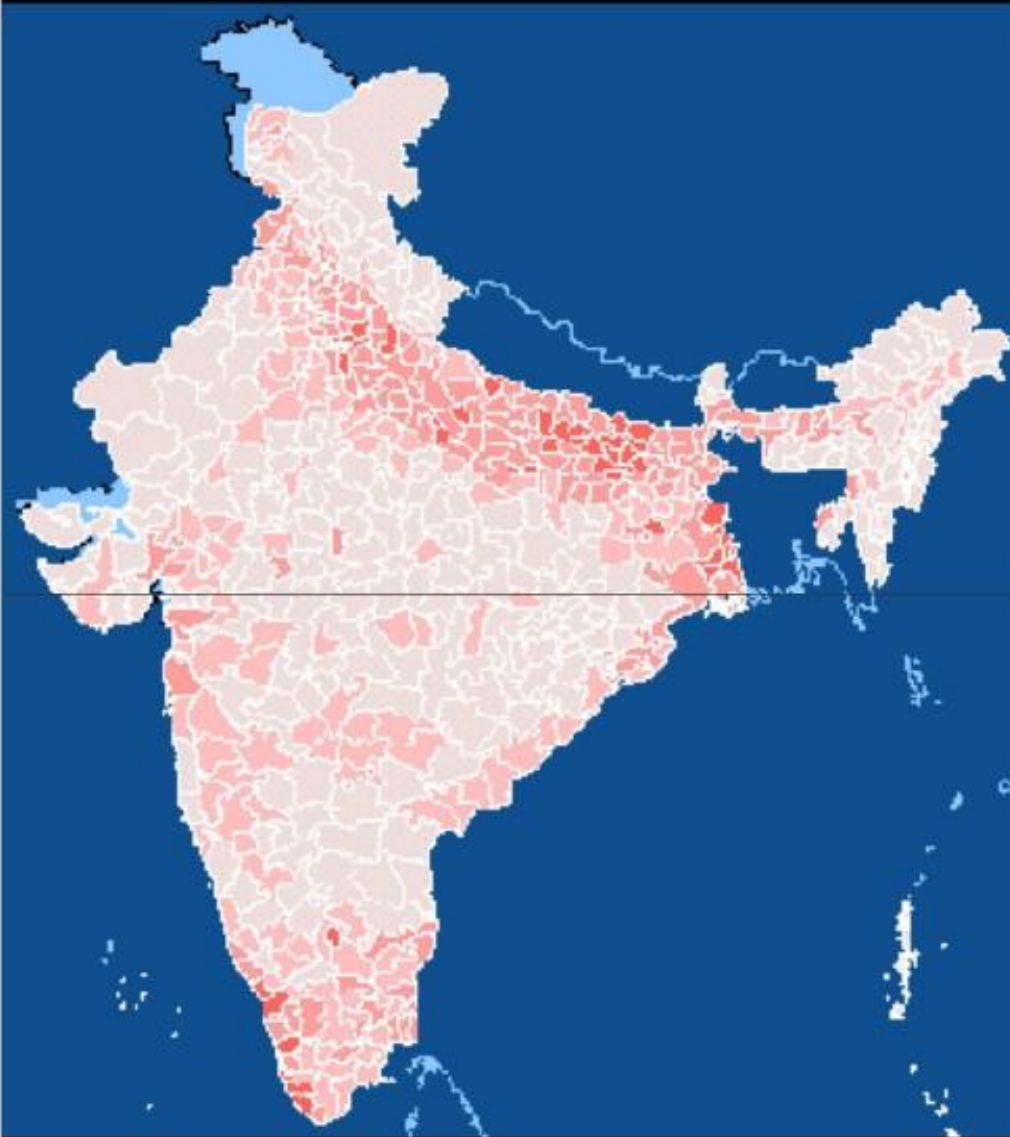
Huge population

Low per capita income

Poor penetration of health care to all sections of society



# INDIA



Total Population\*

1,028,737,436

Male to Female Sex Ratio\*

1000:933

Literacy rate\*

64.8%

Per Capita Income\*

US\$ 430

72% of India lives in rural surroundings with very little access to decent healthcare\*

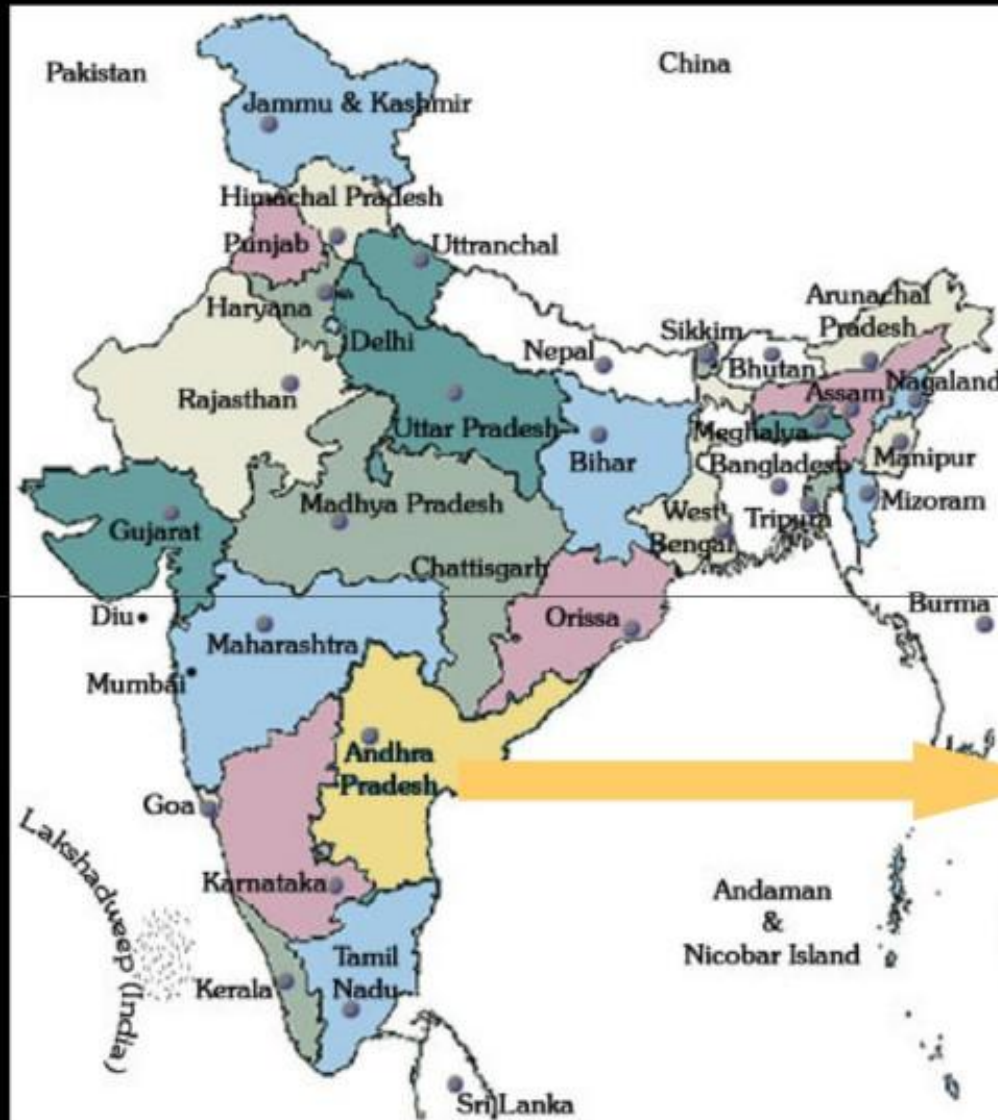
\* Source: Census of India 2011



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# Andhra Pradesh



**Area\***

275,000 sq. km

**Literacy Rate\***

61.11%

**Population\***

75,727,000

**Per Capita Income\***

US\$ 650



INDIA

Andhra Pradesh State

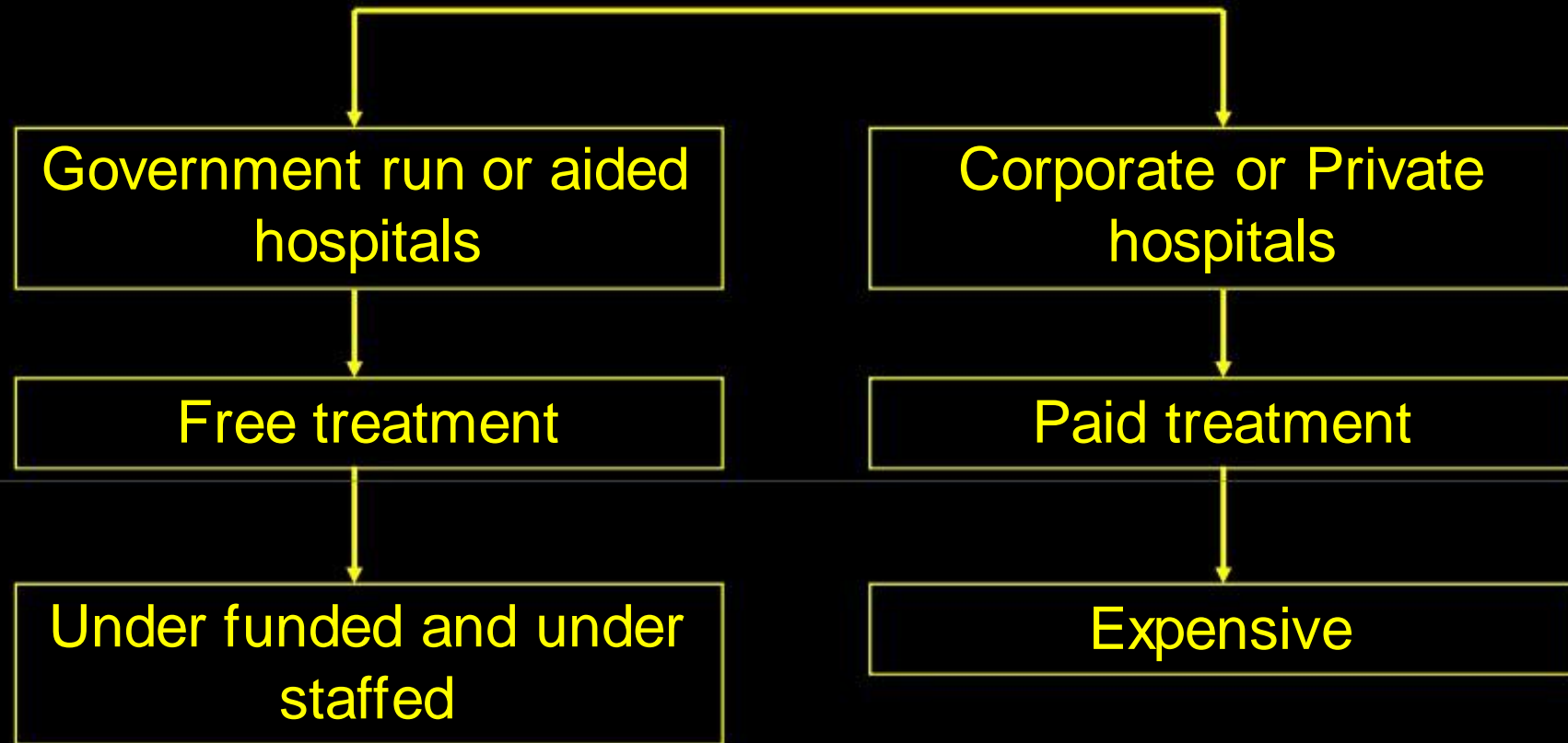
\* Source: Directorate of Economics and Statistics, Government of Andhra Pradesh



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# Health care system in India



< 10% of Indian population have recourse to health insurance

Do we have an alternative way of treating patients?



## Original Article

### Incidence of cleft Lip and palate in the state of Andhra Pradesh, South India

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#### ABSTRACT

**Objective:** To assess the incidence of cleft lip and palate defects in the state of Andhra Pradesh, India. **Design Setting:** The study was conducted in 2001 in the state of Andhra Pradesh, India. The state has a population of 76 million. Three districts, Cuddapah, Medak and Krishna, were identified for this study owing to their diversity. They were urban, semi-urban and rural, respectively. Literacy rates and consanguinity of the parents was elicited and was compared to national averages to find correlations to cleft births. Type and side of cleft were recorded to compare with other studies around the world and other parts of India. **Results:** The birth rate of clefts was found to be 1.09 for every 1000 live births. This study found that 65% of the children born with clefts were males. The distribution of the type of cleft showed 33% had CL, 64% had CLP, 2% had CP and 1% had rare craniofacial clefts. Unilateral cleft lips were found in 79% of the patients. Of the unilateral cleft lips 64% were left sided. There was a significant correlation of children with clefts being born to parents who shared a consanguineous relationship and those who were illiterate with the odds ratio between 5.25 and 7.21 for consanguinity and between 1.55 and 5.85 for illiteracy, respectively. **Conclusion:** The birth rate of clefts was found to be comparable with other Asian studies, but lower than found in other studies in Caucasian populations and higher than in African populations. The incidence was found to be similar to other studies done in other parts of India. The distribution over the various types of cleft was comparable to that found in other studies.

#### KEY WORDS

Cleft lip & palate incidence; cleft lip; cleft palate

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#### INTRODUCTION

Oral-facial clefts, particularly cleft lip with (CLP) or without (CU) cleft palate and cleft palate alone (CP) are a major public health problem affecting 1 in every 500 to 1000 births worldwide.<sup>[1,2]</sup> A child is born with a cleft somewhere in the world

Srinivas Gosla Reddy et. al.

Incidence of Cleft Lip and Palate in the state of Andhra Pradesh, South India

Indian Journal of Plastic Surgery, 43(2):184-189, July 2010.



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Incidence of cleft defects in the state of Andhra Pradesh

1.09 in 1000 live births

Number of Children born with cleft defects in the state of Andhra Pradesh

1830 every year



## Congenital Anomalies Associated with Cleft Lip and Palate Defects in a High Volume Indian Centre

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### Abstract

**Objective:** The objective of this study was to find the prevalence of associated anomalies in patients with cleft lip and palate defects. A number of associated anomalies were noticed by the authors while routinely examining patients with cleft and craniofacial defects at their center. An accurate study to identify the prevalence of associated anomalies in cleft lip and palate patients was needed, to emphasize the need for a thorough investigation of children with cleft lip and palate and the need for a multidisciplinary team to diagnose cleft lip and palate. There was also a need to study the impact of associated anomalies on the burden of cleft care in a developing country like India.

**Design and Setting:** This is a retrospective study of 800 consecutive patients with cleft lip and palate CL-184, CLP-532, CP-84 seen in the year 2006. The data was collected retrospectively by processing the case history of the patients. The patient's cleft defect, age and sex was noted along with the religious background, level of income and consanguinity. The anomalies were classified under 10 headings depending on the organ system affected.

**Results:** Associated anomalies were present in 330 cases (41.3%). The highest prevalence of 46.4% was found in patients with cleft lip and palate. The lowest prevalence of 27.7% was found in isolated cleft lip patients. There was no significant difference of prevalence found between unilateral or bilateral clefts and complete or incomplete clefts. The skeletal system was affected the most. Anomalies of the skeletal system count for 42% of all anomalies. Logistic Regression was used to calculate if any of the other background data increased the chance of having an associated anomaly showed that having an isolated cleft palate decreased the chance of having an associated anomaly as was being a Muslim or from another religion as compared to being a Hindu. Other background data did not have a statistically significant chance to have an associated anomaly with clefts.

**Conclusion:** There was a high prevalence of associated anomalies in the study done at this center. There was, however a need to study the reasons for such anomalies further. There is also a need to study the impact of such anomalies on the burden of cleft care in developing countries.

**Key words:** cleft lip, cleft palate, congenital anomalies, associated anomalies, high volume centre.

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7, 2011.



## Summary of the Issue

### Burden of Care

- High Incidence of
  - Clefts (1.09 in 1000 births) and
  - Associated anomalies (41.3% of cleft patients)
- Very few treatment centers
- Lack of funds to treat patients
- Lack of infrastructure
- Lack of awareness



## The GSR Institute of Facial Plastic Surgery, Hyderabad

Treatment for patients is focused on one part of the body thus making it easy for patients to identify their problems and receive treatment.

(Problem with face = GSRIFPS)

Money raised for a specific purpose benefiting both the donor and recipient.

Easy to build an administrative system for a hospital treating only one part of the body.

Funds received can be completely utilized to treat patients.

Infrastructural or administrative expenses can be justified as they are solely used for the work that funding is received for.





## The Mandate

- |                   |  |
|-------------------|--|
| 1. Patient/Client | To treat patients with cleft and craniofacial defects at no cost or low cost                     |
| 2. Infrastructure | To build good, durable infrastructure without compromising on quality                            |
| 3. Doctors        | To build and sustain a team of doctors and professionals that would do this work all year round. |



# The GSR Institute of Facial Plastic Surgery

## From 1996

- Very little Infrastructure.
- Five member part time team of surgeons, anesthetists and dentists.
- Visit seven surrounding districts of Hyderabad two days a week.
- Only surgery is done. No orthodontics or speech therapy.
- Patient pays INR 1,000 (\$25) per surgery for material used during an operation.



# GSR Institute of Craniofacial Surgery To 2015



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# GSR Institute of Craniofacial Surgery

## Cleft team:

- 2 Surgeons, 5 Fellows,
- 3 Anesthesiologists,
- 3 Speech therapists,
- 2 Orthodontists and 10 nurses.

## Infrastructure

- 2 operating rooms,
- 6 bed post operative facility,
- 40 bed patient ward
- Speech therapy unit,
- Dental and orthodontic unit
- Photography and documentation







2 surgeons operating in 2 dedicated operating theaters



6 Beds Post operative ICU





Nasendoscopy



Nasometry



Orthodontics and Dentistry



OPG Lat. Ceph

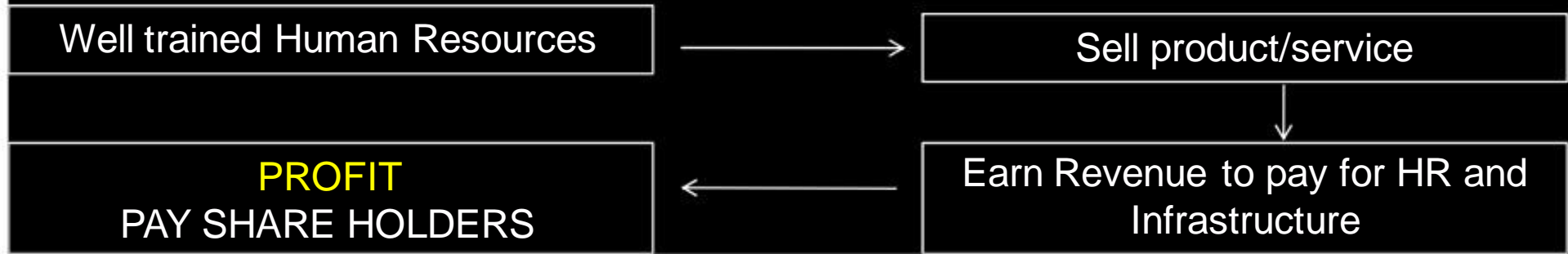




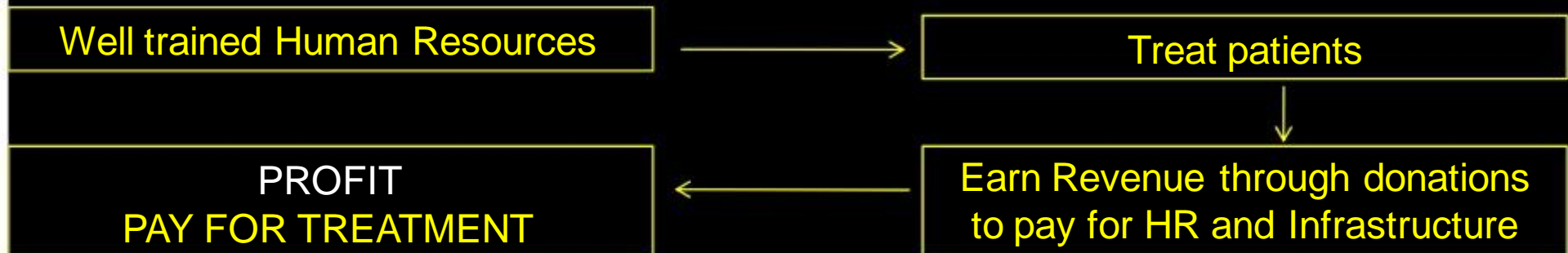
# We treat our Cleft Team as a corporate entity!!!

How???

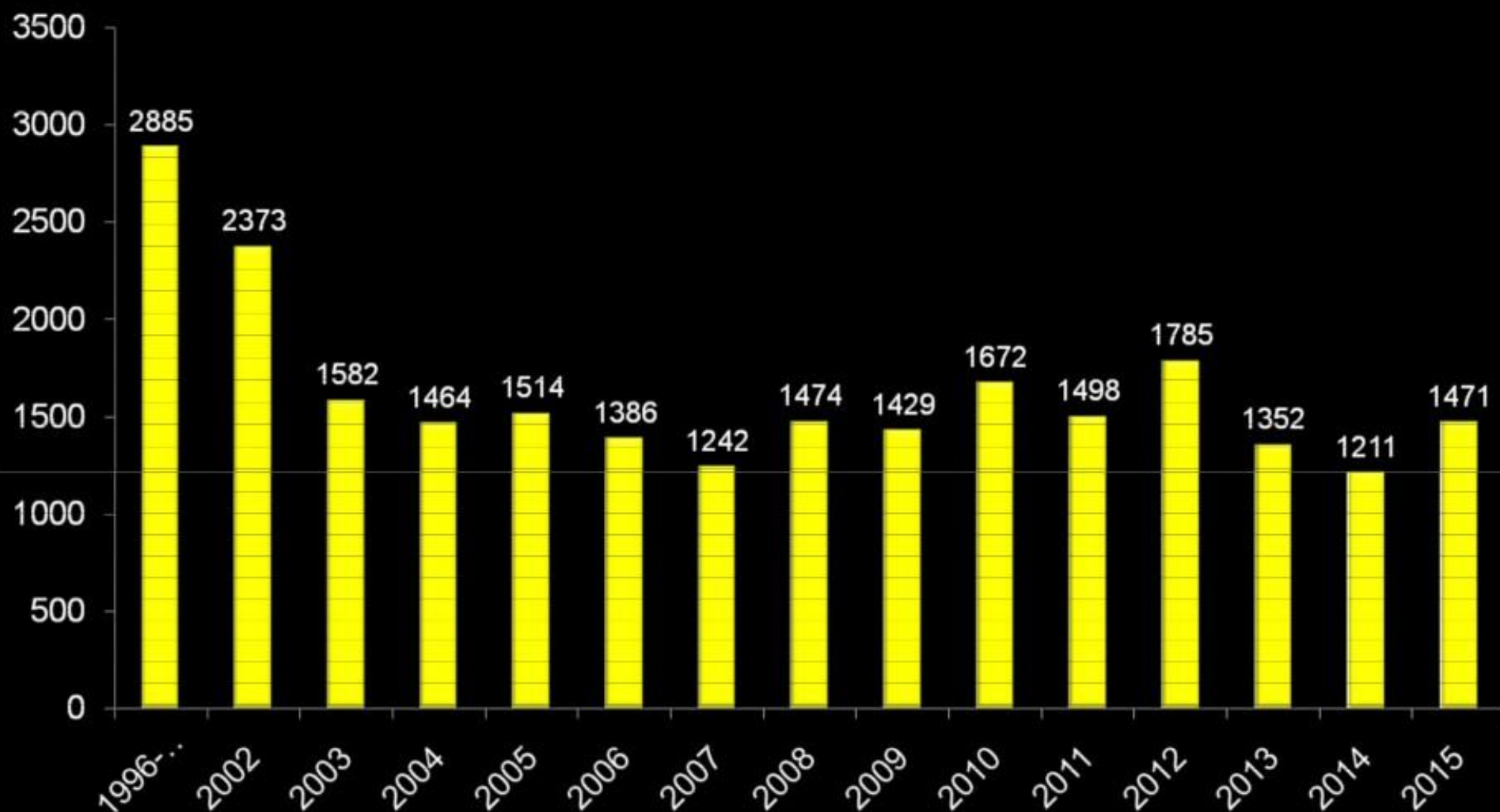
## Corporate Philosophy



## Humanitarian Philosophy



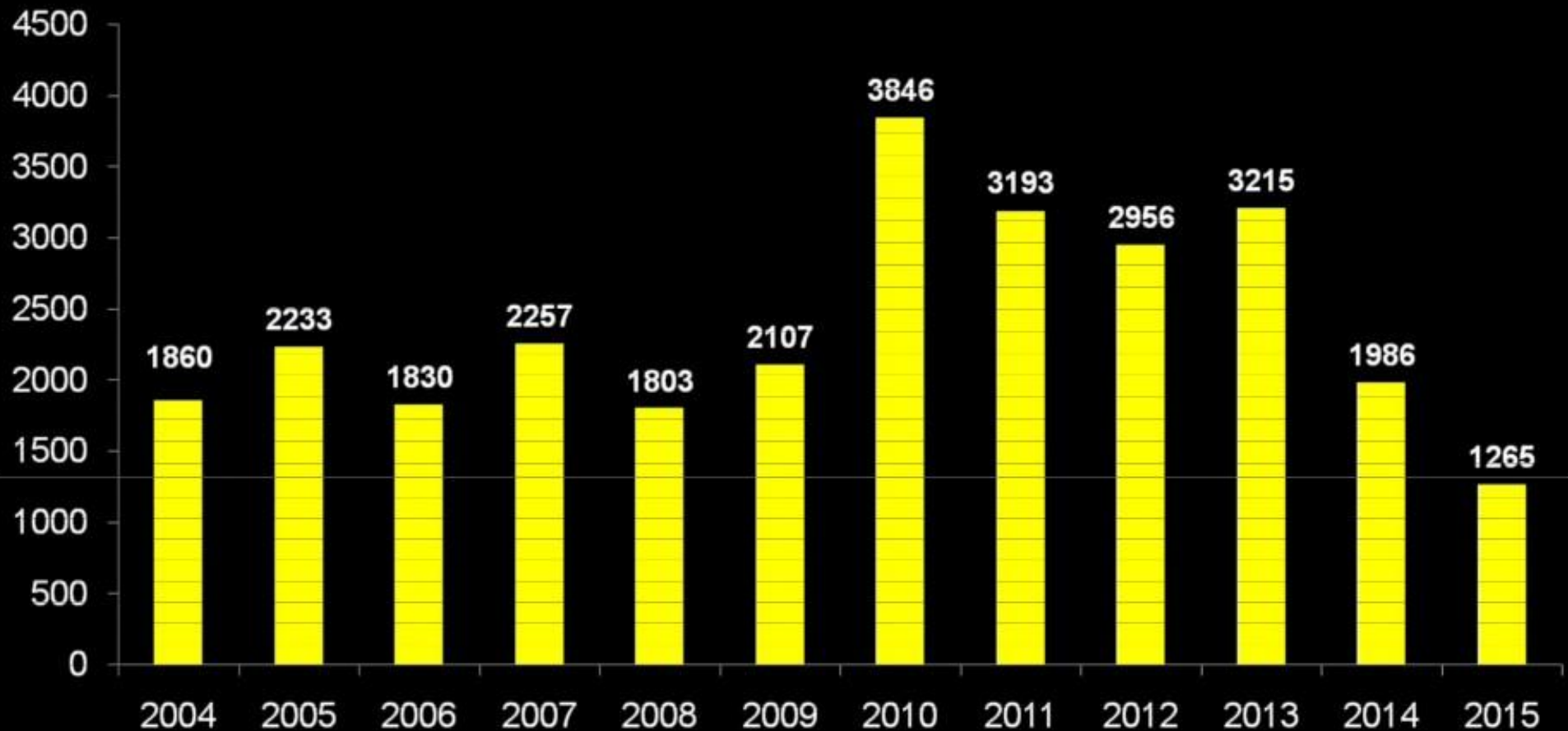
# Cleft Surgeries



Total Cleft Surgeries: 24,338



# Cleft Speech Therapies

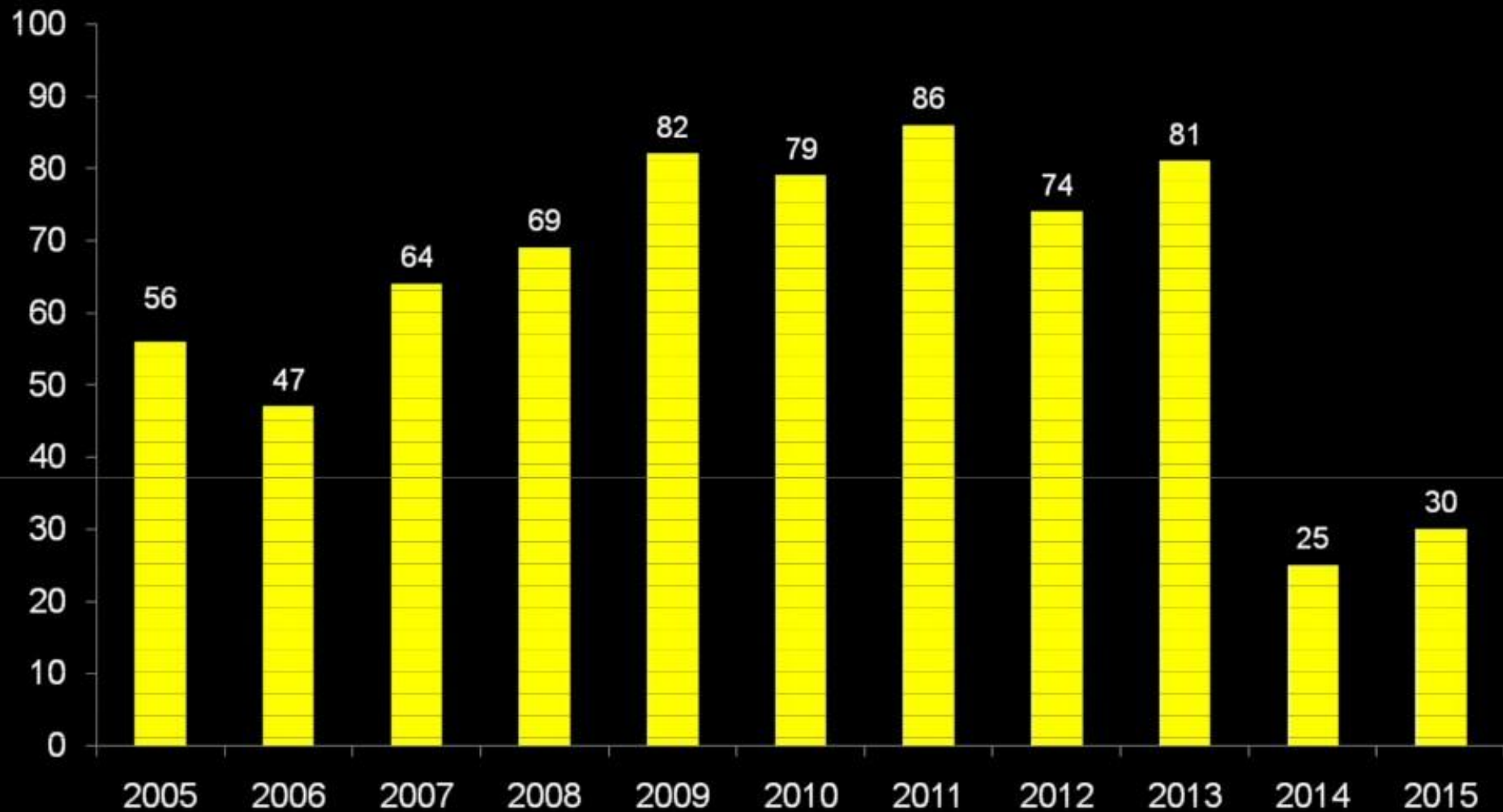


Total Cleft Speech Therapies: 28,451



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# Cleft Orthodontic Treatments



Total Cleft Orthodontic Treatments: 693



## What did we achieve?

- Huge numbers in patient care
- Establishment of good infrastructure
- Stand alone craniofacial center
- Dedicated craniofacial team

## What did we lack?

- Ideology development
- Research
- Cutting edge technological advancement



# COLLABORATE



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# Ideology Development

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University of Antwerp,  
Antwerp, The Belgium



# Research



UMC  St Radboud



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## Original Article

### Incidence of cleft Lip and palate in the state of Andhra Pradesh, South India

Srinivas Gosta Reddy, Rajagopal R. Reddy, Eswar M. Brankhorst\*, Rajendra Prasad\*, Arsha M. Elstam\*, Hermann F. Sailer\*, Stefan A. Borge\*

OSR Institute of Craniofacial Surgery, Hyderabad, Andhra Pradesh, India; \*Department of Cardiology and Preventive Dentistry, Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands; \*\*A. B. Shetty Memorial Dental College and Hospital, Mangalore, Karnataka, India; \*Department of Oral and Maxillofacial Surgery, Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands; \*Carl Utzinger International, Zurich, Switzerland

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#### ABSTRACT

**Objective:** To assess the incidence of cleft lip and palate defects in the state of Andhra Pradesh, India. **Design/Setting:** The study was conducted in 2007 in the state of Andhra Pradesh, India. The state has a population of 76 million. Three districts, Guntur, Nellore and Krishna, were identified for this study owing to their diversity. They were urban, semi-urban and rural, respectively. Literacy rates and consequently of the parents was elicited and was compared to national averages to find correlations to cleft lip and palate. Type and side of cleft was recorded to compare with other studies around the world and other parts of India. **Results:** The birth rate of clefts was found to be 1 in 100 for every 1000 live births. This study found that 50% of the children born with clefts were males. The distribution of the type of cleft showed that 32% had CL, 54% had CLP, 2% had CP and 1% had non-transverse clefts. Unilateral cleft lip was found in 70% of the patients. Of the unilateral cleft lip, 64% were left sided. There was a significant correlation of children with clefts living near to parents who showed a consanguineous relationship and those who were illiterate with the cleft rate between 5.25 and 7.21 for consanguinity and between 1.55 and 5.85 for literacy, respectively. **Conclusion:** The birth rate of clefts was found to be comparable with other Asian studies, less lower than found in other studies in Caucasian populations and higher than in African populations. The incidence was found to be similar to other studies done in other parts of India. The distribution over the various types of cleft was comparable to that found in other studies.

#### KEY WORDS

Cleft lip & palate incidence; cleft lip; cleft palate



#### INTRODUCTION

Oral-facial clefts, particularly cleft lip with (CLP) or without (CUP) cleft palate and cleft palate alone (CP) are a major public health problem affecting 1 in every 500 to 1000 births worldwide.<sup>1,2</sup> A child is born with a cleft somewhere in the

## ORIGINAL ARTICLE

### Developing and Standardizing a Center to Treat Cleft and Craniofacial Anomalies in a Developing Country Like India

Srinivas Gosta Reddy, MD, MBB, \* Laksh V. Reddy, DDS, MSD, JRCR,† and Rajagopal R. Reddy, BDS, MBBS\*

Abstract: The range of facial deformities is enormous. All produce some degree of disfigurement and result in the impairment of function to some degree, sometimes even to the point of incompatibility with life. Congenital facial defects in India are associated with considerable superstition, social rejection, and failure to integrate into society.

In India, cleft defects occur in 1 in 100 births. Congenital facial defects are a growing problem in India owing to the immenseness of the poor masses, poverty, the high illiteracy rates, and involving well-entrenched human mores.

Setting up an institute to treat children with cleft and craniofacial deformities in India presents problems with financing resources for such a facility in a developing country and the issue of finding the right location are important factors to consider while considering a center for patients with cleft and craniofacial anomalies.

The aim of setting up such a center was to provide quality comprehensive treatment for patients from all sections of society with cleft and craniofacial anomalies.

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J Craniofac Surg 2009;20: 1664-1667

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Journal of Cleft Lip and Palate & Craniofacial Translational, Vol. 1, No. 1

### Congenital Anomalies Associated with Cleft Lip and Palate Defects in a High Volume Indian Centre

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#### Abstract

**Objectives:** The objective of this study was to find the prevalence of associated anomalies in patients with cleft lip and palate defects. A number of associated anomalies were noticed by the authors while routinely examining patients with cleft and craniofacial defects at their center. An accurate study to identify the prevalence of associated anomalies in cleft lip and palate patients was needed to emphasize the need for a thorough investigation of children with cleft lip and palate and the need for a multidisciplinary team to diagnose cleft lip and palate. There was also a need to study the impact of associated anomalies on the burden of cleft care in a developing country like India.

**Design and Setting:** This is a retrospective study of 800 consecutive patients with cleft lip and palate (CL=104, CLP=151, CP=44) seen in the year 2006. The data was collected retrospectively by reviewing the case history of the patients. The patient's cleft defect, age and sex was noted along with the religious background, level of education, occupation, the number of children, and the number of siblings depending on the organ system affected.

**Results:** Associated anomalies were present in 130 cases (16.5%). The highest prevalence of (16.4%) was found in patients with cleft lip and palate. The lowest prevalence of (7.7%) was found in isolated cleft lip patients. There was no significant difference of prevalence found between unilateral or bilateral cleft and complete or incomplete clefts. The dental system was affected the most. Anomalies of the dental system were found in 62% of all anomalies. Epiglottic dysplasia was noted in 10 cases (1.25%) of the other background data increased the chance of having an associated anomaly; showed that having an isolated cleft palate decreased the chance of having an associated anomaly; and that having a cleft lip or cleft palate as compared to being a Hindu. Other background data did not have a statistically significant chance to have an associated anomaly with clefts.

**Conclusion:** There was a high prevalence of associated anomalies in the study done at this center. There was, however, a need to study the reasons for such anomalies further. There is also a need to study the impact of such anomalies on the burden of cleft care in developing countries.

**Key words:** cleft lip, cleft palate, congenital anomalies, associated anomalies, high volume center

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# Choice of Incision for Primary Repair of Unilateral Complete Cleft Lip: A Comparative Study of Outcomes in 796 Patients

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F.R.C.P.S.,  
Harshad Jaiswal, BDS,  
David Hughes, and Christiaan Van

**Background:** No one technique of cleft lip repair consistently produces ideal aesthetic and functional results. This study was carried out to develop a high-volume center. It compares outcomes attained using two different designs of skin incision used for primary closure of unilateral complete cleft lip and sought to identify the most appropriate technique for clefts of varying morphology.

**Methods:** Seven hundred ninety-six patients were entered into the study. In each group of slightly less than 400 patients, either a modified Millard or Phyllis earl flap incision was used, both in conjunction with functional repair of the underlying tissues as described by Delmon. Soft-tissue measurements of the lip and nose were recorded preoperatively. Analysis was based on postoperative assessment of the philar roll, vestibular border, nose, Cupid's bow, lip length, and mouth symmetry and appearance of the skin donor and nose.

**Results:** Comparison of the two cohorts using Pearson chi-square testing for associations and linear trend found a Millard incision gave significantly better results for vestibular notch, whereas the Phyllis method led to a better postoperative lip length. Postoperative data on particular technique was better suited to certain preoperative cleft anatomical features were not proven statistically.

**Conclusions:** Certain preoperative anatomical features may lead the surgeon to choose one particular incision pattern in preference to another, but in this study, it was found that one technique was generally superior to the other. This suggests that the technique for closure of the underlying tissues is probably of more importance. (Plast Reconstr Surg 121: 832, 2008.)

**S**urgeons have repaired the deformity of cleft lip for the past 2000 years, since the first attempt performed during the Chou Dynasty in China.<sup>1</sup> Many techniques have been used since that time, and it is clearly apparent that no agreement exists as to which represents the optimum method.

Historically, incisions have been either straight line or broken line, but more recently, in the twentieth century, flap design developed over two distinct periods. In the first, up to 1948, and including Le Mosnier,<sup>2</sup> lengthening of the lip on the cleft side was

achieved with some sacrifice of the ipsilateral Cupid's bow. This concept, however, tended to produce an aesthetically undesirable wrinkling of the lip. In the second half of the century, several attempts were made to correct this shortcoming. Tanskanen<sup>3</sup> utilized a triangular flap on the external surface of the lower margin of the lip, while Pitt and Pannier<sup>4</sup> used a superiorly based flap. Nevertheless, because of some controversy, this latter approach also produced unacceptable aesthetic outcomes. A combination of superior and inferior flaps was used by Tanskanen<sup>3</sup> and Shogin<sup>5</sup> to counter these problems. A further alternative was described by Maki,<sup>6</sup> who used a flap based on a precisely measured ipsilateral triangle to achieve perfect equality in the length of

**Disclosure:** None of the authors has any financial interest in this work, and no competing interests are declared.

From the GOS Institute of Craniofacial Surgery, the South Coast Higher Surgical Training Program in Maxillofacial Surgery, the Division of Oral and Maxillofacial Surgery, University of Cincinnati, David Rossini and Development Support Unit, Brunel University and Dental Gift Centre (London); for publication March 24, 2008; accepted December 15, 2008.  
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## Afroze Incision for Functional Cheiloseptoplasty

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**Abstract:** Repair of unilateral cleft lip is a demanding and challenging procedure. Although a great number of operations have been described for the unilateral cleft lip repair, none have all the plastic surgical criteria, and in most cases, cleft lip repair requires secondary operations in an attempt to achieve desired goals of primary cheiloplasty. The Afroze incision is a combination of 2 incisions, that is, the Millard incision on the mouth side and Phyllis earl incision on the cleft side. The flap design is the Millard flap on the mouth side toward downward, and the peak of the distal curve of the Phyllis earl flap is positioned in the triangular defect formed by the movement of the Millard flap. The postoperative lengthening downward to reverse the Millard's "C" flap. The advantage of this technique is that there is no tension on the postoperative nose because the incision is essentially horizontal in nature, and the compression of the nose occurs horizontally rather than vertically. Primary nasal reconstruction is performed, which provides stability and most positioning of the previously lifted ear of the cleft side and nasal tip and the nose can grow in a balanced way with equal vascular flow being secured on both sides. This incision can be used in all types of complete unilateral cleft lip regardless of the nose or alar cleft, including the cleft lip-nose.

**Key Words:** Complete unilateral cleft lip, Afroze incision, cheiloseptoplasty.

(J Craniofac Surg 2009;20: 1733-1736)

**R**epair of unilateral cleft lip is a demanding and challenging procedure. The aim of a unilateral cleft lip repair is to achieve a lip length on the cleft side matching that on the normal side, an inconspicuous nostril rim that does not cause aesthetic imbalance, an adequate Cupid's bow with an absence of wrinkling of the vestibular border (sublabial lip inflexion), and an absence of puckering of the vermilion at the Cupid's bow on the cleft side. Although a great number of operations have been described for the unilateral

cleft lip repair, none fulfill all the above criteria, and in most cases, cleft lip repair requires secondary operations in an attempt to achieve the desired goal.<sup>1</sup>

The Millard incision is based on a rotation flap on the mouth (medial) side coupled with an advancement flap on the cleft (lateral) side. One of its main advantages is that the technique allows adjustment as the operation proceeds, with further rotation and advancement movements tailored to the individual case. It requires the approximation of a pair of corner curves that ultimately may have a cleft extending the surface on the base of the columella. The Phyllis earl incision is designed using the concept of "neurologic axis."<sup>2</sup> Measurements of mouth side length and length are recorded and transferred to the cleft side using a double wire, thus allowing natural anatomic points. The 2 curves are brought together such that the highest and lowest points of 2 curves are approximated with the corresponding highest and lowest points of the other, thus creating a straight line.<sup>3</sup>

On comparison of the 2 techniques, each has its own advantages and disadvantages. The Millard flap produced better results when considering vestibular approximation. In this respect, it is rather more flexible than a straight line design, and the operation is able to produce the rotation flap on the mouth side where it is judged likely to produce the best outcome. This technique also has an improved outcome where preoperatively the lip is wider on the mouth side. This would tend to a reduction in tension on approximation of the flap on the mouth side, resulting in less distortion and a Cupid's bow with better form. Despite using flaps according to Phyllis earl's design resulted in a better length of lip postoperatively for its nature, the more tension incorporated in the incision, the greater the length of the lip. A permanent wire placed just above the measurement junction will tend to exaggerate this factor.<sup>4</sup>

Afroze incision is a combination of 2 incisions, Millard incision on the mouth side and Phyllis earl incision on the cleft side. The flap design is such that Millard flap on the mouth side is rotated downward, and the peak of the distal curve of the Phyllis earl flap is positioned in the triangular defect formed by the movement of the Millard flap. The postoperative lengthening downward to reverse the Millard's "C" flap. The advantage of this technique is that there is no tension on the postoperative nose because the incision is essentially horizontal in nature and the compression of the nose occurs horizontally rather than vertically. There is also no pressure on the Cupid's bow for the same reason.

### INCISION MARKING

On the mouth side, the Cupid's bow is marked by 2 points. Point 1 is the highest point on the central nasal alar cleft, point 2 is the deepest point on the white roll. Point 3 is marked on the white roll at a distance that is 2 mm more than the distance between points 1 and 2.

On the cleft side, point 4 is marked at a point where the white roll begins to fade (Figs. 1-3). The Millard incision on the mouth side is extended from point 1 along the junction of skin and vestibular mucosa and further







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 Isolated, Registered, Italy  
 Foreign, Germany, New Orleans, La.  
 International, Grand Glasgow, and  
 America, The Netherlands

**Background:** The aims of this study was to compare the clinical outcomes of two techniques to repair complete bilateral cleft lips by using indirect two-dimensional photographs.

**Methods:** One hundred eighty bilateral cleft patients were included in this study. 38 patients operated on with the Millard technique and 34 patients operated on with the Abbou technique. Each group of patients was further separated into two subgroups containing symmetrical and asymmetrical cleft lips. All patients were photographed preoperatively and 4 times postoperatively in frontal and subnasal views in a reproducible way. Eight measurements were taken from the photographs and compared with the preoperative values. The results were calculated to compare the two techniques.

**Results:** The comparison of the interobserver and intraobserver measurements were analyzed using the Pearson correlation test. There was a statistically significant reliability in the interobserver and intraobserver ratings. Analysis of the results was performed using the independent samples *t* test (5% level of significance). The interobserver test for the three categories was better than the Milrod technique in all of the seven parameters for non-surgical cloth and in four of the seven parameters for commercial cloth. However, this is not statistically significant in all cases, since the *p* value of the non-surgical cloth was 0.05.

**Conclusions:** The *Allograft* technique seems to have good clinical outcomes on Unilateral cleft lip patients, but more research and long-term follow-up are needed to determine the full outcome of the technique in various patient cases. (*Ann Plast Surg* 2016; 77: 403-414, 2017).

CLINICAL QUESTION/LEVEL OF EVIDENCE: Therapeutic, III.



**N**o greater problem exists in the whole field of surgery than the successful treatment of patients suffering from complete, bilateral cleft lip-cleft palate repair.<sup>1</sup> The challenge is to construct the maxillofacial complex in three dimensions, incorporating soft and hard tissue and

underlying two-dimensional changes of growth and distortion.<sup>2</sup>

A number of surgical procedures with many variations have been reported for the treatment of the cleft lip. The Millard technique has been well described.<sup>1-3</sup> The Millard technique and its variations are extensively used to repair bilateral cleft lip. The Abbe technique is based on transposition of a variation of the Millard technique on the cleft segment and a variation of the Phyllis technique on the protrusion. The aim of this study was to compare the clinical outcomes of the Millard technique and the Abbe technique by using indirect photographic measurements in treating bilateral cleft lips.

**Disclosure:** The authors have no financial interest to declare in relation to the content of this article.

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## Options for the nasal repair of non-syndromic unilateral Tessier no. 2 and 3 facial clefts

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[illegible]

Facial vessels: Terminal vessels: Terminal cap. 2 (left); Terminal cap. 3 (right)

**A** facial cleft is the result of a partially or totally missing fusion of the embryonic craniofacial tissue. The severity of the deformity can range from slight skin creases and hair loss to very mouth, closed eyes and the absence of nose and face, seriously impairing the patient's appearance and function.

Facial clefts are usually found along the lines of fusion of the different embryonic processes responsible for the development of the face during the first 8 weeks of embryonic life.<sup>10</sup>

The incidence of these craniofacial malformations is higher in cleft lip, alveolar and palate patients (21/1000 live births) cleft lip and palate than in people without cleft lip, alveolar, and palate.<sup>21</sup> Facial clefts have been classified according to pathologic aetiology, pathomorphology, topographic anatomy and at the time of development.<sup>22-24</sup> Tissue is anatomically based classification is, presently, almost universally used by craniofacial surgeons.<sup>25</sup> Tissue no. 2 and 3 facial clefts are lateral nasal clefts that are located at the junction between the products of the median and lateral nasal processes.<sup>26</sup>



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All authors are grateful to the United Arab Emirates University, National University of Science and Technology, Islamabad, Pakistan, for their support.

**Background:** The aim of this study was to evaluate symmetry of the lip and nose in patients with CUCNP after primary rhinoplasty (different techniques). In comparison to non-

**Methodology:** In the prospective study, 1000 patients with approved non-invasive (NIV) were included. The control group consisted of 40 subjects without risk factors.

**Results:** For all measurements, the control group was up to 50% slower to perform recovery compared to the TUEEP group after primary surgery. This difference was statistically significant.

**Conclusion:** After primary cholecystectomy according to the African technique a patient with CHCP, asymmetry in the neck and lip area will occur as compared to non-right handed. Although non-right individuals also show some degree of asymmetry, the results of this study stress the difficulty in obtaining near-normal anatomical relations.

Key words: cleft palate, three-dimensional imaging, maxillofacial surgery, nose, rhinoplasty, 3D visualization, anatomy, volume

**INTRODUCTION**

The ultimate goal for repair of the complex valvular defect, aortic and patent (CUCAP) deficiency is to create normal aortic flow and function. This aim has resulted in a plethora of techniques and innovations to optimize the aortic and functional results. However, the management of CUCAP deficiency, essentially that of the aortic regurgitant aortic

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Various studies [14] have been undertaken to evaluate the results of different operative procedures to correct the CLSIF most effectively. However, quantification of rhegmatogenous globe tears remains difficult. Besides direct ophthalmoscopy, numerous means [5] studies comparing pre- and postoperative tear and the changes in oculars with vitreous body. But it is less discussed.

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## Intraoperative Vascular Anatomy, Arterial Blood Flow Velocity, and Microcirculation in Unilateral and Bilateral Cleft Lip Repair

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**Background:** Cleft lip repair aims to normalize the disturbed anatomy and function. The authors determined whether normalization of blood circulation is achieved. **Methods:** The authors measured the microcirculatory flow, oxygen saturation, and hemoglobin level in the lip and nose of controls ( $n = 22$ ) and in patients with unilateral and bilateral cleft lip–cleft palate. The authors measured these parameters before lip repair ( $n = 29$  and  $n = 11$ , respectively), at the end of lip repair ( $n = 27$  and  $10$ , respectively), and in the late postoperative period ( $n = 33$  and  $n = 20$ , respectively). The arterial flow velocity was measured in unilateral groups at the same time points ( $n = 13$ ,  $n = 11$ , and  $n = 12$ , respectively). Statistical differences were determined using analysis of variance. **Results:** Before surgery, the arterial flow velocities and microcirculation values were similar on each side of the face and between groups. The microcirculatory flow was significantly higher in the prelabium of unilateral patients than in the philtrum of controls. All circulation values in unilateral and bilateral patients in the late postoperative period were within the range of controls and of those before surgery. Intraoperatively, the authors consistently found a perforating artery on the superficial side of the transverse nasalis muscle. **Conclusions:** There appears to be no intrinsic circulatory deficit in unilateral and bilateral cleft lip–cleft palate patients. The increased flow in the prelabium indicates a strong hemodynamic need in this territory, compelling its vascular preservation. Whether surgical preservation of the nasalis perforator artery is of long-term benefit should be addressed in future studies. (*Plast. Reconstr. Surg.* 130: 1120, 2012.) **CLINICAL QUESTION/LEVEL OF EVIDENCE:** Therapeutic, V.

Cleft lip repair techniques differ mainly in the design of the skin incisions, how the muscle portions are reconstructed, and how the nasal framework is repositioned.<sup>1</sup> The vascular anatomy has remained largely unaddressed in current

surgical techniques, and the reasons for this have yet to be explored.

Normal blood supply is a precondition for development and growth. Thus, it would be of clinical interest to determine whether cleft anatomy leads to a change in the blood supply before or after surgery.

Current techniques for cleft lip repair exclude surgical anastomosis of the lip artery. However, this clinical approach is not based on blood circulation data and so the current standard must be challenged. Vascular damage in cleft surgery interrupts the existent hemodynamics and necessitates further trauma to stop the bleeding, after which the blood circulation may take several months to recover.<sup>2</sup> Gentle surgical soft-tissue han-

From Craniomaxillofacial Surgery, University Hospital Basel, the HighTech Research Center of Craniomaxillofacial Surgery, University of Basel; the G. S. R. Institute of Craniomaxillofacial and Facial Plastic Surgery; the Anatomical Institute, Microanatomy and Multidisciplinary Anatomy, Laboratory for Functional Macromorphology; and Cleft Children International CCI. Received for publication January 17, 2012; accepted May 23, 2012.

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**Disclosure:** None of the authors has any conflicts of interest to declare.



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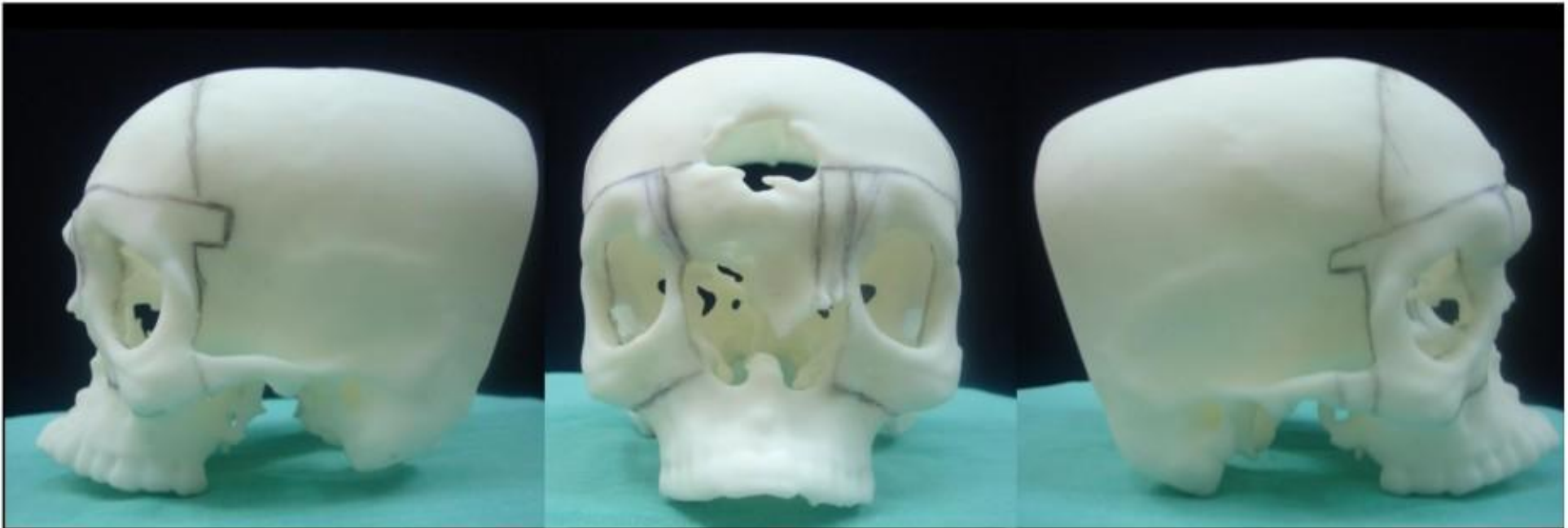
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Sadan, Saidabad, Hyderabad, 500059, Telangana, India</p> <p>Dear Dr. Gosla Reddy:</p> <p>The intent of this communication is to share with you the changes that the IACOMS Board of Directors, the Foundation Board of Trustees, and the Fellowship Committee will implement regarding the Fellowship program in the next few months. After carefully reviewing the GSR Institute of Craniofacial and Facial Plastic Surgery's impressive annual report, the Boards and Committee would like to officially invite you to serve as Program Director and host one Fellowship recipient specializing in cleft lip &amp; palate and craniofacial surgery at the GSR Institute in Hyderabad, India for a period of six months each year starting in 2015-2016. The fellowship recipient will spend the other six months in Bangalore to complete a one year program. On behalf of the IACOMS Board of Directors and the Fellowship Committee, we thank you in advance for your hospitality and your devotion in advancing OMFS surgery education.</p> <p>We look forward to hearing from you.</p> <p>Best regards,</p>    <p>Fran Brown President, IACOMS</p> <p>Larry Brown Chairman IACOMS Foundation</p> <p>E.E. OHSEI Chair IACOMS Fellowship Program</p> <p>cc: IACOMS Board of Directors Nobeli Samman Pierre Deloy</p>	<p><b>EUROPEAN ASSOCIATION OF CRANIO MAXILLO FACIAL SURGERY</b></p> <p><a href="http://www.eacmf.eu">www.eacmf.eu</a></p>	<h2>EACMFS FELLOWSHIPS</h2> <ul style="list-style-type: none"> <li>CLEFT SURGERY</li> <li>FACIAL COSMETIC SURGERY</li> <li>HEAD &amp; NECK ONCOLOGY</li> </ul> <p><b>CRITERIA FOR FELLOWSHIPS:</b></p> <ol style="list-style-type: none"> <li>The applicant should be a member of IACOMFS</li> <li>The Fellowship Centre should be accredited by EACMFS or any of the Fellowship Committee members</li> <li>The applicant should be a qualified specialist in maxillofacial surgery according to the regulations to be applicable in his/her home country – or in the country in which he/she has acquired specialty training</li> <li>Approval for leave of absence should be obtained from the employing authority</li> <li>Clinical or basic research is required. At least one paper referring the said research must be submitted for publication to the Journal of Cranio-Maxillo-Facial Surgery. Following submission of the paper, the Fellow must cooperate and respond to all requests from the Journal's editor or editorial staff to complete the review process</li> <li>Financial resources should be available for covering the one-year stay at the host centre with a position paid for by either the home centre, or the host centre, or by a grant that enables the applicant to perform a study while staying at the host centre</li> <li>A complete CV, a log book of operations performed and a list of scientific publications [as published by the applicant plus written proof of all the above shall be sent to the Secretariat</li> </ol> <p><b>FINANCIAL SUPPORT:</b></p> <ol style="list-style-type: none"> <li>A maximum of 2000 euros per individual fellow will be available as a subsistence allowance at the start of the Fellowship</li> </ol> <p><b>NUMBER OF FELLOWSHIPS:</b></p> <ol style="list-style-type: none"> <li>A maximum of three fellows per group will be accepted per year</li> </ol> <p><b>CLEFT SURGERY</b> Host Centres: Belgium Prof Hanser Naeyens India Prof Srinivas Gosla Reddy</p> <p><b>FACIAL COSMETIC SURGERY</b> Host Centres: Belgium Prof Maurice Maemuraets Germany Dr Arvid Hill UK Dr Brian Mungovan</p> <p><b>HEAD &amp; NECK ONCOLOGY</b> Host Centres: Croatia Prof Milan Vring Germany Prof Robert Seiler UK Dr Nicholas Silverman</p> <p><i>Host Centres under Development Process: Italy, Pakistan, Spain, Africa, The Netherlands and others</i></p>	<p><b>AOCMF</b></p> <p>GSR Institute of Craniofacial Surgery Prof. Dr. Srinivas Gosla Reddy 17-1-38355, Vinay Nagar Colony, I. S. Sadan, Saidabad Hyderabad 500059 India</p> <p>21st April 2015</p> <p>Approval of your AOCMF Fellowship Host Clinic Application</p> <p>Dear Professor Srinivas Gosla Reddy,</p> <p>we are writing to you with regards to your AOCMF Fellowship Host Clinic Application, submitted on October 5th 2013. It is our pleasure to inform you that the members of the International Board have approved your application at their last AOCMF International Board Meeting in Davos.</p> <p>In order to initiate the next steps, you will be contacted by the AOCMF Fellowship organizers soon. Enclosed to this letter, please find your AOCMF Host clinic certificate.</p> <p>We are proud to add the GSR Institute of Craniofacial Surgery, to our AOCMF Fellowship training centers and congratulate to your approval.</p> <p>Kind regards</p>  <p>Warren Schubert International Board Chair</p>
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**GIVE AND PASS ON THE KNOWLEDGE THAT YOU HAVE  
ABSORB KNOWLEDGE THAT OTHERS CAN GIVE AND PASS ON**

A SUCCESSFUL CLEFT CENTER CAN ONLY BE A **CONFLUENCE OF IDEAS**  
THAT **EMPLOYS WELL TRAINED PERSONNEL** AND IS **WELL EQUIPPED** TO  
DEAL WITH THE PROBLEM





# Bring the Smile Back



## Thank You



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