

CLEFT LIP RESIDUAL DEFORMITY CORRECTION

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KEY WORDS

Maxillary Hypoplasia, Nasal deformity.

ABSTRACT:

Cleft lip residual deformities need a Careful assesment of disfigurement and distortion related defects.

Lip and nose both develop them after the successful primary repair. That of nose are related to collumela, alar cartilages, septum both bony as well as cartilagenous and vesitibules. Surgical correction of each and every one of the defects present is expected to give a functionally and aesthetically acceptable result. Proper understanding of skeletal structural support of nose and that of certain other elements on which nose skin is draped is necessary. This artical deals with finer aspects of deformities that develop in cleft lip noses and describes ways and means of correcting them.

INTRODUCTION

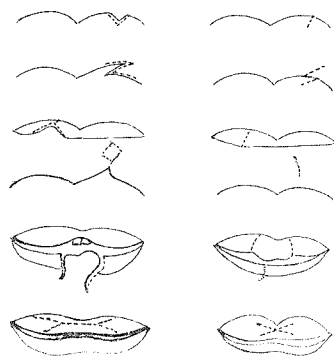
In surgical correction of congenital defect experienced and competent plastic surgeon takes every possible care to achieve satisfactory result. Severity of defect present however decides the final outcome of such an effort.

In a moderate cleft repair if it is carried out at the right age and in a healthy patient the result in immediate post operative period, looks good and continues to appear so through to adult hood. Behaviour of others of severe degree is unpredictable since early excellent result, worsens through each stage of physical development and disproportion, distortion, and disfigurement becomes noticeable and shows up as a deformity in need of further corrections.

MATERIAL AND METHODS

47 cases of cleft lip nose of unilateral and bilateral variety of all age groups where primary repair was carried out by author as well as elsewhere are a subject of present study.

In patients one or more defects were noticed and they are listed and methods used for their corrections against each defect are mentioned.



Sketch --Deformity (Lip)

- 1) Step deformity
- 2) Mucocutaneous junctional defect.
- 3) Vermilian tissue malalignment.
- 4) Vertical scar contracture.
- 5) Whistle lip deformity.
- 6) Insufficient vermilian visibility.

DISCUSSION

Total- 41

Unilateral Lips	Nos	Mostly used technique
Step deformity; Vermilian tissue malalignment.	9.	Z plasty.
Muscle deficit in scar. Tight closure. Unsightly scar and filtrum	23.	Scar revision.
	1.	Re-repair.
	1.	abbey's flap.
	17.	Scar revision and buried conchal cartilage graft-
Insufficient vermilian visibility.	3.	Y-V advancement of vermilian tissue.
Vertical scar contracture.	10.	Diamond wedge resection and linear closure.

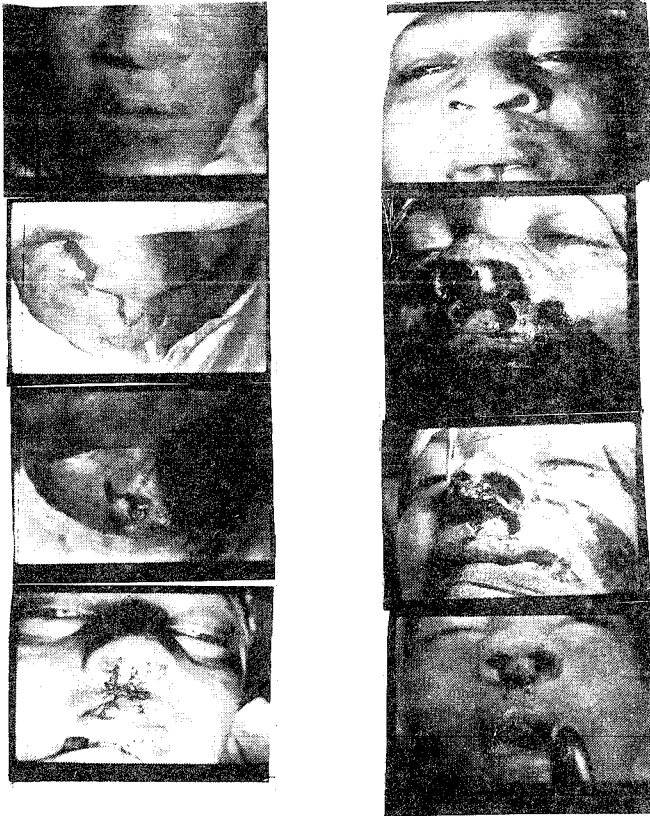
Total 6

Bilateral lips.	Nos.	Mostly used Technique
Whistle lip deformity.	2.	Scar revision Abbey's flap.
Prolabial muscle deficit.	4.	Double breasting after muscle dissection and scar revision.
Vermilian tissue malalignment cupids bow and filtrum loss,	6.	Vermilian scar revision.
	6.	composit conchal graft to produce ridge:

Nose	Nos.	Mostly used Technique
i Collumelar Skin Deficit	25	Millards fork flap
ii Alar Posterior Placement on affected side	34	On Lay Cartilage, Bone, rib graft.
iii Lateral Axial Deviation of Nose	17	unequal osteotomies
iv Unequal Anterior Naris Vestibules	40	Reconstruction of Nasal Tip
v Subluxated Septal Cartilage & Resultant External Nasal Deformity	32	Rhinoplasty by E.R.A.

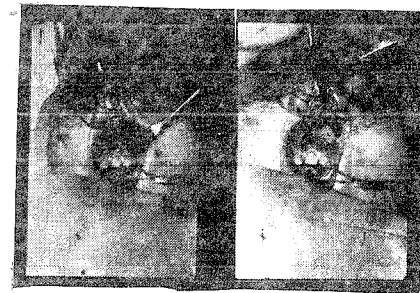
Lip defects are relatively easy to correct and different ways of their repair are well documented in text books. Correction of defects of cleft lip nose

are under process of intensive in depth study and are getting better defined with each successive attempt. The results of surgical corrections are improving and reaching to an acceptable improvement levels-



Collumelar skin deficit: Correction by Millard's fork flap technique is a well documented and an established method, but precise age at which this should be undertaken is not well defined. If deficit present is realised early and is corrected in childhood, it prevents distortion of the collumelar alar angle and the transferred added tissue is given enough period to settle well through growing years. On adults when this is carried out it always takes length of time for oedema to subside and to achieve desired result. This short collumela essentially is a skin shortage and collumelar cartilages spring back

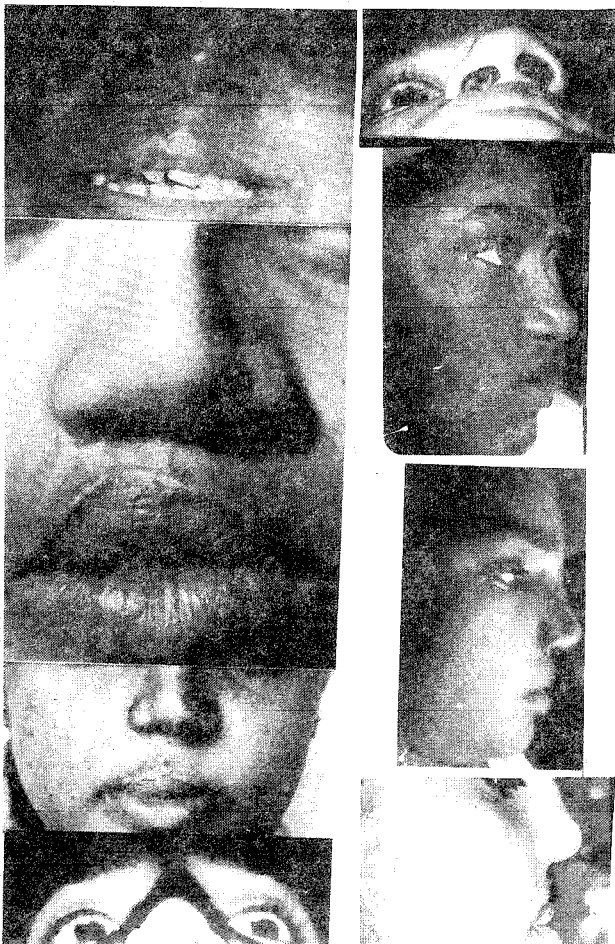
to normal lengths as soon as skin attachment is freed in the process of lengthening.



Alar posterior placement on cleft side: In unilateral clefts, hypoplastic maxilla of the affected side causes sinking of alar base posteriorly, and that results in a lopsided appearance of the nose. Correction of this deformity is possible by an onlay graft of either cartilage wedge which is periodically changed to bigger size as child grows or on adults by a onlay cartilage/bone graft on the affected side depending on the size needed, to achieve symmetry.

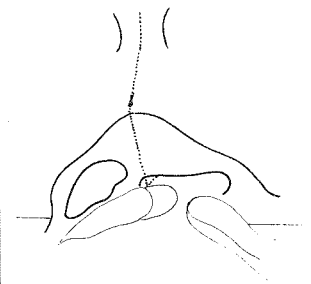
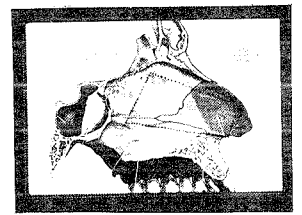


Lateral Axial deviation of nose: Where as nasal bones develop normally in unilateral clefts and the internasal suture is in midline, lateral deviation starts at the cartilagenous junction and proceeds downwards to the tip. Its correction is



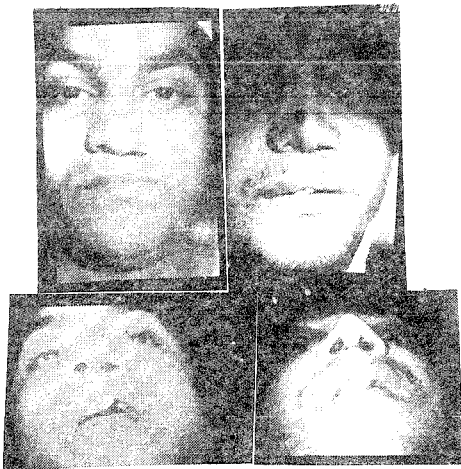
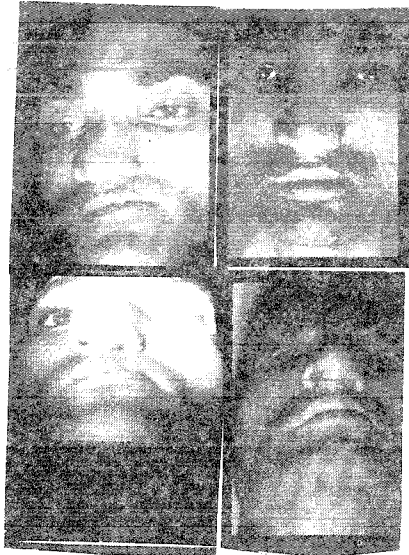
possible by unequal lateral osteotomies during Rhinoplasty.

Vesitibular Asymmetry. All above factors mentioned contribute to it and the deformed dome of the tip needs proper construction into a pyramid. This needs saperation of alar cartilages from their skin attachments, trimming of their caudal edges and may also necessitate alar flare reduction at the alar bases by wedge resections to achive final acceptable improvement.



Subluxated nasal septum: Due to maxillary hypoplasia the poorly developed spine is unable to hold on to the affected side the base of vomar all along its length from anterior nasal spine to its posterior in midline.

The lateral pull of the cleft side skin and cartilages presses it downward resulting in its sublxation on the cleft side at its base and the top attached to the cartilage gets pushed to the apposite side,leading to lateral axial diviationof the nose to the noncleft side. This also results in blocking normal nasal airway. Septal cartilage, portion of vomar and part of perpendicular plate of ethemoid



needs removal to establish normal airway and to restore function.

External nasal deformity: This is best corrected by ERA approach, by attending to the alar cartilages, by doing a unequal lateral osteotomy, by an onlay graft over hypoplastic maxilla dorsal nasal augmentation and if necessary by wedge resection of the alar bases.

CONCLUSION

Secondary cleft lip deformity correction is a daunting task More so of the cleft lip nose. Need is to understand the problem fully and then to carry out reconstruction is a meticulous mannan. Avery large number of adult patients need this surgery and

are coming forward for the same in ever increasing numbers.

Above described procedures have proved helpful in arriving at a satisfactory solution.

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