

“Children born with cleft lip or palate need ongoing care”

The staff at Mountain Region Speech and Hearing Center would like to take this time to provide some general information about children born with a cleft lip/palate. According to the Center for Disease Control and Prevention, approximately 2,651 babies are born with a cleft palate and approximately 4,437 babies are born with a cleft lip (with or without cleft palate) a year in the United States. With the advances in technology, some clefts of the lip and even palate are now being seen during ultrasounds. This allows parents time to understand and educate themselves prior to the birth of their infant.

The term orofacial cleft is used to categorize all clefts of the face; cleft lips, palates, and submucous clefts. An orofacial cleft forms when during the first three months of pregnancy. The lip and/or palate of the fetus do not form together. The majority of orofacial clefts can be grouped into the following categories: cleft lip without cleft palate, cleft palate without cleft lip, cleft lip and palate. Unilateral is used to note that the cleft occurs on the left or right side; bilateral is used to describe a cleft that encompasses both the left and right side of the mouth.

The roof of your mouth is formed by a hard (bony) and soft (muscular) palate. A cleft of the palate is when there is an opening, or incomplete fusion, of the hard and/or soft palate. This allows the inside of the infant's mouth to have a direct opening in their nasal cavity. Infants born with a cleft palate may initially have difficulty with feeding; this may lead to a referral to a speech pathologist. During feeding evaluation the speech pathologist will assess the infant in a variety of feeding positions and with different types of bottles and nipples to help the infants' with eating. The speech pathologist will analyze how the cleft palate is affecting the infant's ability to create a negative pressure system to suck from a bottle.

Infants born with a cleft palate are at increased risk for speech sound disorders as they grow. After the infants have completed all of their surgeries to close the palate, parents should continue to monitor their development of sounds. Also, research has found that these children have higher incidences of language delay. Early evaluation and treatment for these speech and language delays is recommended.

The location and severity of a cleft lip will often determine if intervention by a speech pathologist is required. For some infants, they are able to easily feed and later easily pick up their speech sounds. For others, they may have difficulty creating a seal around the bottle, and may require different positioning or a different bottle. As they grow, it is important to monitor their development of sounds that require movement of the lips (m, p, b). If the child avoids these sounds or does not appear comfortable with these movements, treatment by a speech pathologist is recommended. The pathologist will assist in teaching the child how to correctly use his/her lips during the sounds.

A submucous cleft results when the outer layer of skin along the roof of the mouth forms completely; however, the inner musculature that supports function of the palate does not form together. A submucous cleft may go undetected for several years or until the child begins to use sounds and communication. Often a noticeable difference in the “nasal” quality of the individual's speech leads to further evaluation of the soft palate function. The child may sound like too much air is coming out of his/her nose when talking or like he/she constantly have a cold (not enough air coming out of his/her

nose). An evaluation by a speech pathologist and often evaluation of the soft palate movement by an ENT allows for an accurate diagnosis of a submucous cleft.

Treatment for a submucous cleft is dependent on the severity and the symptoms. After a complete evaluation, a trial period of speech therapy to target soft palate movement may be recommended before more invasive measures. A speech pathologist can work with the child to teach him/her how to incorporate soft palate movement into their speech. In some cases surgical intervention is required prior to the initiation of speech treatment.

What contributes to the incomplete closure of lip/palate continues to be researched. For some children the resulting orofacial cleft is secondary to a syndrome. A family history of orofacial clefts and environmental factors such as medications, lack of key nutrients and exposure to cigarette smoke are thought to increase the risk of orofacial clefts.

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