

LETTER TO THE EDITOR

The Present State of Treatment in Cleft Palate: What Still Needs to Be Done

In my personal review, cleft palate treatment has entered a new era of evidence-based practice, and society is demanding that clinicians deliver treatment that has been proven to be cost-effective. Although randomized clinical trials in cleft palate have never been performed, there is still excellent evidence from serial studies starting at birth that can be translated into clinical practice. This information will provide evidence for establishing public health policy and treatment planning to maximize good long-term outcome at reduced state and parent costs.

The following information describes the essence of how team care should be given by trained and knowledgeable specialists who come together to supply appropriate care in all physical and emotional areas.

THE TEAM APPROACH

With the institution of a team approach to the care of children with craniofacial anomalies, the level of care improved as each of the specialists, having gained a better understanding of the problems involved, became more prepared to pool their efforts to solve rehabilitative problems that lend themselves to a multidisciplinary approach. Team members not only are to be well-trained in their specialty but also must be experienced. It demonstrates that records consisting of serial lateral cephalometric radiographs, dental casts, photographs, speech and audiologic reports must be taken for quality assurance. A family-centered approach to treatment, team qualifications and responsibilities, and an operational guide for meeting their goals are reviewed in detail.

CONCERN FOR THE WHOLE CHILD

A cleft of the lip and/or palate and other craniofacial anomalies are structural defects that usually affect functional areas (such as those involving speech, hearing, and chewing) depending on the extent of the skeletal defect. Complex problems with feeding, facial appearance, speech and hearing function, and psychosocial development may arise. All of these problems can be managed best by bringing many specialists in related disciplines together to review the physical and psychological changes arising from the defect and to coordinate all treatment to the best advantage of the patient and parents.

QUALIFICATIONS OF TEAM MEMBERS: TO BE TRAINED AND EXPERIENCED

The paramount interest of both the Bureau of Maternal and Child Health and the American Cleft Palate Craniofacial Association is the quality of care for patients. It is essential that all team members be trained and experienced in the care of patients with craniofacial anomalies. The education and experiential requirements for the specialists represented on teams are determined by their specialty boards, professional associations, state licensing boards, and so forth. The requirements are continually subject to change. Each team must take responsibility for ensuring that team members not only possess appropriate and current credentials but also have requisite experience in evaluation and treatment of patients with craniofacial anomalies. Teams should assist members in keeping current with their specialties by supporting and encouraging participation in continuing education activities and attendance at professional meetings.

SURGERY AND ORTHODONTICS

The past 50 years demonstrates the excellent progress that has been achieved toward a better understanding of all aspects of the cleft defect and its rehabilitation. Not only has the outlook for a newborn child with a facial defect been substantially improved, but the cost of treatment in dollars, time, and heartache has also been reduced.

ADVANCES IN SURGICAL TREATMENT

Each team should monitor both short-term and long-term outcomes. Follow-up of patients, using appropriate documentation and record keeping, is essential. Following the birth of a child with a cleft lip, palate, or craniofacial anomaly, the attending obstetrician, pediatrician, nurse, or social worker may—if he or she is involved with a cleft palate team—be sufficiently well-informed to outline the general problems to the parents and to provide guidance.

PRESENT STATE OF TREATMENT

The clinical outcome papers given at recent cleft palate association meetings clearly show strong differences in treatment concepts between cleft palate centers. In the main, these differences are reflected at the newborn period. Some clinics use time-tested surgical procedures whereas

others use protocols that have never been supported by published outcome studies.

William Shaw and Gunvor Semb (2013) reported the results of a multicenter treatment outcome study in Europe (Eurocleft). They concluded that this lack of association between treatment outcome and intensity may represent a key lesson for the development of future protocols. It justifies an emphasis on simplicity, economy, and minimized burden for the patient rather than adherence to demanding protocols with unsubstantiated promise. Professionals entrusted with the provision of health care have an obligation to review the success of their practices and where shortcomings are revealed, to take remedial action. Such efforts should constitute a continuous cycle, sometimes known as clinical audit. This has been defined as "the systematic critical analysis of the quality of care including procedures for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient." Often, efforts in clinical audit are divided into evaluating the process of care (the way in which it is delivered) and the outcomes of care (what is achieved). Cycles of outcome audit are more easily established when the intervention is common and the consequences are clear-cut and quickly observable. Cleft audit, therefore, involves a considerable challenge because of the lengthy follow-up required; the complexity, subtlety, and number of relevant outcomes; and, above all, the relatively low number of cases. However, intercenter collaboration still offers significant advantages by providing insights into the processes and outcomes on treatment of comparable services elsewhere, the establishment of future goals, and the exchange of evidently successful practices.

A strategy to improve care would be to assemble an archive of relevant clinical records that are considered to be representative of good practice, perhaps drawn from the consecutive cases of respected centers. Provided other centers collect equivalent records, matching of cases on relevant characteristics would enable comparisons to be made. This could be performed by the center in question "behind closed doors" or, if preferred, with more transparency. For example, the center's cases could be mixed with the archive cases and independently rated or rated by a blind panel involving the center's own personnel.

THE NEED FOR SPECIALISTS TO BE KNOWLEDGEABLE: WHAT TO DO AND WHEN TO DO IT

(2013)

Berkowitz was very interested in solving the problems associated with reaching residents in all specialties involved in cleft palate care. He strongly believed that all specialists on a cleft palate team should know and understand all the functional problems and treatments involved in each specialty. To accomplish this goal, he created a 7-hour audio visual lecture online. As stated in the description of what constitutes a knowledgeable cleft palate team member, each specialist must understand all the possibilities that can occur over time as the child grows. For example, an anterior maxillary crossbite can negatively affect developing speech. This presentation emphasizes the role of the team orthodontist as a monitor of the effects of the surgical protocol on facial growth and development. It emphasizes the need to recognize that differential diagnosis in treatment planning is required since all clefts, although similarly classified, are different in bone deficiency as well as variations in facial growth patterns.

A Core Curriculum outline for cleft palate team members has been created by the Education Committee of the American Cleft Palate-Craniofacial Association (ACPA) to be used as a guide for educators in these various disciplines in planning the essential parts of their curriculum related to cleft and craniofacial anomalies. It was created after a survey by ACPA of educators in these disciplines, showed a need for such an outline.

In the current context of limiting health dollars and resources, it is predictable that some rationing decisions will occur. The deciding principle to be applied is "no child will go untreated," but it is contingent on all specialists maximizing the outcome even with limited financial resources.

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REFERENCE

- Shaw W, Semb G. Title. In: Berkowitz S, ed. *Cleft Lip and Palate: Diagnosis and Management*. 3rd ed. Heidelberg, Germany: Springer Verlag; 2013:XX-XX.