FDI POLICY STATEMENT

Management of Cleft Lip and Cleft Palate

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CONTEXT

Cleft lip (CL) and cleft palate (CP) are the most common congenital deformities of the head and neck.[1] The available data indicates that the overall prevalence of cleft lip and palate (CLP) is approximately 1 in 700 live births with considerable ethnic and geographical variation.[2]

Orofacial clefts are associated with soft tissue and skeletal and/or dental defects.[3,4] Children born with CLP may have moderate to severe malocclusion,[5,6] and may face severe difficulties with breastfeeding, eating, speaking, hearing, smiling and even breathing, all of which can have both physical and psychosocial impacts and can affect quality of life.[7-9]

CLP is associated with social and psychiatric morbidity affecting patients and caregivers.[10]

Dentists, orthodontists, and oral and maxillofacial surgeons must intervene at various stages of growth and development of patients in coordination with other healthcare providers.

Teamwork over the long term is essential to realize successful treatment outcomes. CLP teams must focus on outcome assessments, and all members of a CLP team must understand the importance of continuous evaluation to refine clinical protocols in the future.

SCOPE

This Policy Statement highlights the multidisciplinary and sequential management of CL, CP and CLP, and the important role of general dentists, paediatric dentists and orthodontists in the multidisciplinary care team.

PRINCIPLES

CLP treatment is multidisciplinary and requires a coordinated effort by specialists at different stages of patients' growth and development. Coordinated teamwork is

essential for optimizing treatment outcomes. Over time, general dentists, paediatric dentists and orthodontists play significant roles as members in the CLP care team.

POLICY

FDI recommends:

- The creation/inclusion of a Cleft Oral Health module in the community curriculum for general dentists and the development of continuing education programmes for dentists and orthodontists, emphasizing the treatment of CLP as a multidisciplinary effort.

- National dental associations, in countries where an organized system of care for patients with CLP does not exist, should establish centres or networks of health professionals involved in care of CLP patients, including plastic and oral and maxillofacial surgeons, dentists and orthodontists.

- CLP care clinical practice guidelines should be created for the dental team and non-oral health professionals who treat patients with CLP.

- The dental team helps parents and/or caregivers to focus on the importance of good oral health for their children from birth, and this should include an emphasis on the importance of caring for the primary dentition.

- Emphasizing that an ideal orthodontic treatment outcome depends upon maintaining excellent oral hygiene and a well-restored, disease-free dentition.

- Awareness of the possibility of orthopaedic interception from birth and interceptive orthodontics between the age of 5 and 10 years and placement of fissure sealants on first permanent molars. Periapical infection of the primary dentition adjacent to the alveolar cleft should be treated prior to bone grafting.

- Particular emphasis on the dental disease-prevention regimen during the transition from primary to permanent dentition and continuous evaluation of facial growth of paediatric patients with appropriate adjustment of the ongoing treatment plan as required.

- Regular liaison between general dentists, paediatric dentists and orthodontists and other healthcare professionals as well as education and counselling for children with CLP and their caregivers.

KEYWORDS

Cleft lip, cleft lip and palate, multidisciplinary management, oral health quality of life, oral healthcare

DISCLAIMER

The information in this Policy Statement was based on the best scientific evidence available at the time. It may be interpreted to reflect prevailing cultural sensitivities and socio-economic constraints.

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