ANALYSIS OF CLEFT PALATE CASES

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This paper is intended just to report the problems seen in palate and lip cases who had reported to our Institute. The information given in this paper is collected from the case histories. All cases of cleft lip and palate here undergo E.N.T., Audiological, Speech and Psychological examinations, after giving a detailed case history. If necessary, the cases also are referred to the paediatrician or physician for further examinations.

The following Table shows the age and sex distribution of 108 cases that reported to our clinic:

TABLE 1

Age in Years	0-5	5-10	10-15	15-20	20-24	25-30	30-40	40 & above
No. of Cases	35	29	18	12	8	3	1	2

Males 61 and Females 47.

The cases were classified using Veaus' classification, that is

I.	Cleft of the Soft palate only	12
II.	Cleft of the Soft palate and Hard palate upto incisive foramen	47
III.	Complete Unilateral alveolar cleft associated with lip	10
IV.	Complete Bilateral alveolar cleft associated with lip	37

The problems seen in the cleft lip and palate cases, as reported by many people are pathologies or abnormalities of ear, nose and throat, heariflg loss, speech problems and Psychological problems.

Prather and Kos (1968) (in Cleft Palate and Communication by Spriestersbach and Sherman) report, infected adenoids and tonsils, nasal obstruction, allergies,

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upper respiratory infection and middle ear pathologies as commonly seen problems in cleft lip and palate cases. The following Table shows the E.N.T. Problems and other problems seen in case? of the present series:

TABLE 2

Irregular teeth-7	Collapsed Premaxilla-l,	High arched palate-3
Constricted allae-2	Retracted mandible-1,	Infected T & A-6
Allergic conditions-2	D.N.S.-13,	Perforation of drum-5
Ear discharge-7,		

Goodstein (1968) gives a good summary of the studies related to the development of intelligence in cleft palate children. The following Table shows the percentage of cases scoring on intelligence tests. (In this study only intelligence is discussed under Psychological problems).

TABLE 3

I. Q		Below 5O	50-70	70-90	90 and above
s	U		1	2	5
p	PR				
	P		1	1	2
H +	U		2	3	12
S	PR		1	2	1
P	R	1	1	6	18
B	U		1	1	1
L +	PR		3	1	1
P	R	2	2	6	10
U	U				
L +	PR				2
P	R			3	5
Total		3	12	25	66
Percentage		2.76	11.04	23.00	.63.00

Most frequently seen hearing loss among cleft palate population is conductive type, as reported by Drettrer (1962), Masters *et al.*, (1960), Spriestersbach .(1962). 11.96 per cent of the cases studied have shown bilateral conductive hearing loss and 8.28 per cent have shown unilateral conductive hearing loss. The following Table shows the per cent of hearing loss in different types of clefts.

. TABLE 4

		Cond		Mixed		S. N. Loss.	
		U	B	U.	B	U	B
Soft Palate	U	2		1		1	
	PR						
	R						
Hard + soft Palate	U	2	3	1			
	PR	1		1		1	1
	R		3				2
Bil. Hard + Soft . Palate	U						
	PR		1				
	R		6		1		

Only 28 per cent of the total population showed hearing loss. Out of this 8.28 per cent showed unilateral conductive hearing loss and 11.96 per cent of them showed bilateral conductive hearing loss.

It seems not possible to have a separate class as cleft palate speech, under the classification of speech disorders, but still there are some speech problems which are seen in cleft palate population. The present analysis reveals following speech problems. This has been shown below:

TABLE 5. *Speech Problems*

S	U	Nasality	Misart	D. lang	Others
S Pt.	U	4	3	2	
	PR				
	R	4	3		1
S+ H Pt.	U	11	10	3	1
	PR	4	3		
	R	19	21	5	1
Bil Lip + Pt.	U	3	2	1	
	PR	7	4	3	
	R	24	20	7	3
Uni. Lip + Pt.	U				
	PR	1	1	1	
	R	4	4	3	
Total		81	71	25	6
Percentage		74.52	65.32	23	5.52

Hagerty (1954) studied 44 cases with repaired cleft palate and found that nasality was present only in some of them, with varying degree. In our series we have found 74.53 per cent of cases as having nasality. And also 65.32 per cent have shown misarticulation among which majority was substitutions and distortions. In 23 per cent of the population delayed speech and language was also seen.

The intention of the present paper is to show that it is possible to collect useful data regarding the cases. Such data collected from cases reporting to a particular clinic is limited in value because it depends upcn biased, self-reported cases. We cannot generalize from such data because we cannot ever be certain how many other people with similar problems have not reported to the Institute. Therefore such data cannot be generalized for whole cleft palate population. However, this paper is presented with the conviction that similar data from different parts of the country will add to giving a more comprehensive picture of larger population.

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