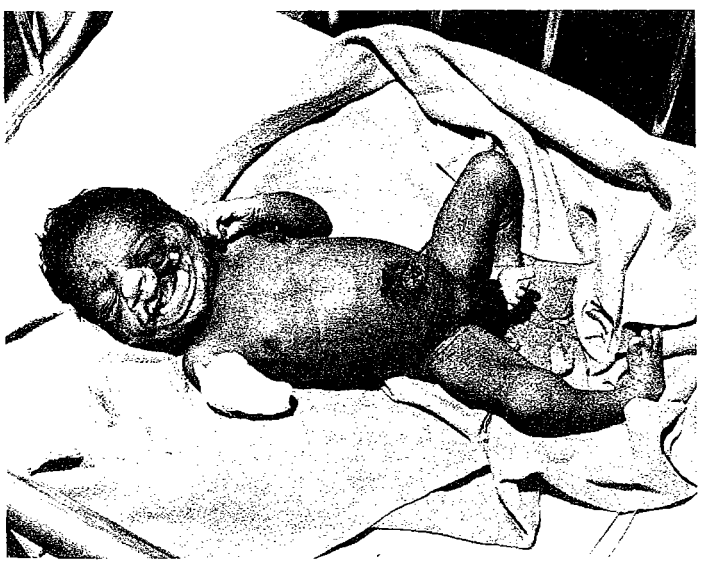
III. Rare Clefts

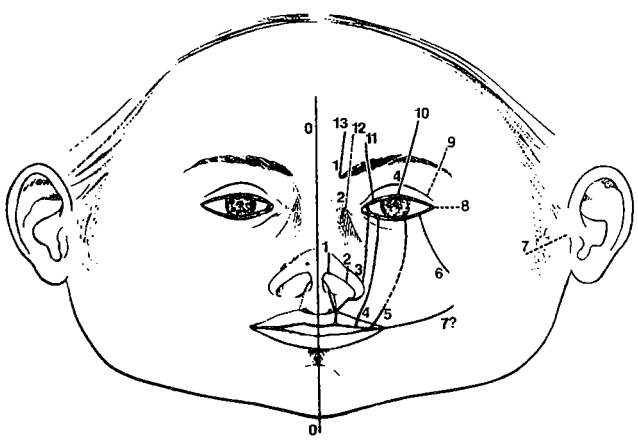
This world is very odd we see,
We do not comprehend it.
But in one fact most all agree,
It's worth a try to mend it.

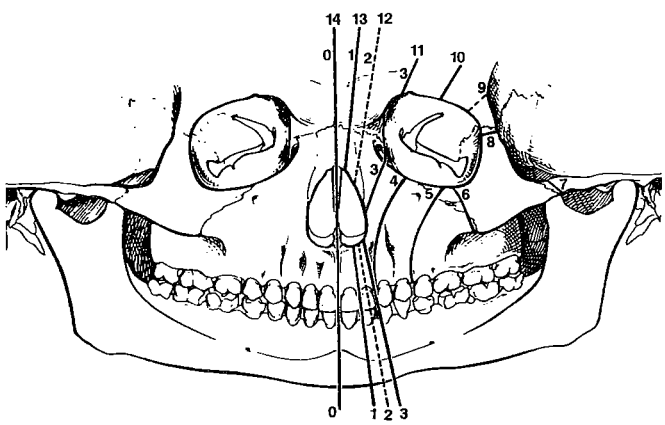


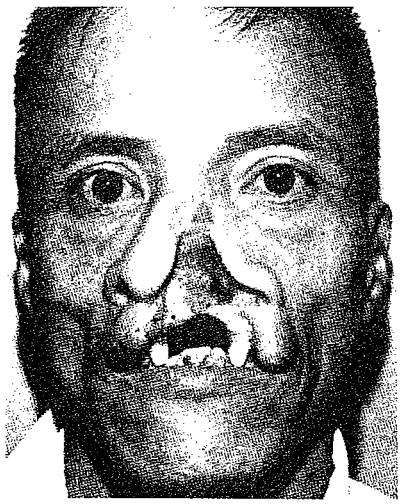
Introduction to Part III

An Interdisciplinary Workshop Conference on the Evaluation of Recent Advances in Cranio-Facial Surgery was held at the University of Illinois Medical Center, November 1974. Resident David Slepyan in attendance at the conference returned enthusiastic about Paul Tessier's classification of craniofacial clefts based on his lifetime collection of cases. Craniofacial and orbitomaxillary clefts are rare malformations, compared to cleft lip and cleft palate, and extend through constant lines or axes through the eyelids or eyebrows, nostrils, lips or maxillae. Bone and soft tissue are seldom involved to the same extent. Soft tissue defects are more common from the midline to the infraorbital foramen while bony defects are more severe lateral to the infraorbital foramen.

It is Tessier's theory that facial clefts have their origin on the cranial base and thus can be traced from the cranium through the orbit to the face regardless of main blood vessels or growth centers. Cleft O represents midline clefts from face to base of







cranium. Clefts 1, 2, 3 are standard cleft lip but traverse the nose at different positions, cleft 1 affecting the alar dome, cleft 2 passing through the mid-alar cartilage and cleft 3 being the more familiar nasolacrimal-ocular cleft. Cleft 4 spares the alar base as it extends to the medial orbit. Clefts 5 and 6 form curved patterns through the cheek, and, since they are lateral to the infraorbital foramen, the bony deficit is greater than the soft tissue deficiency. Cleft 7 is associated with hemifacial microsomia. Clefts 8 and 9 are not well documented. Clefts 10, 11, 12 and 13 are extensions of clefts 4, 3, 2 and 1 above the orbit at the cranial base.

A PRACTICAL APPLICATION

An adult Vietnamese male with a wide unilateral cleft of the lip involving the alveolus but with the columella intact and a unilateral cleft of the alar rim, was discussed by Jean Maes in *Plastic and Reconstructive Surgery,* September 1974. The patient had caused Maes much trouble for not only had he failed to return for scheduled surgery but he refused to fit into a standard classification. Richard Stark, after ruling out noma, interpreted the anomaly as a median cleft of the primary palate and cleft nose with imperfect naris formation. Actually, the case seems to fit quite simply into Tessier's classification of facial clefts as cleft 1, a standard unilateral cleft of the lip traversing the nose at the alar dome.