



## Features of Surgical Methods for the Elimination of Congenital Bilateral Cleft Lip and Palate

Radjabov Amirjon Axtamovich <sup>1</sup>, Abdullaev Kudrat Ergash uglu <sup>2</sup>,  
Hakimov Humoyun Bakhtiyor ogli <sup>3</sup>

<sup>1</sup> Assistant of the Department of Pediatric Dentistry, Bukhara State Medical Institute

<sup>2</sup>, <sup>3</sup>, Master of the Department of Pediatric Dentistry, Bukhara State Medical Institute

**Relevance:** Congenital cleft lip and palate (CCLP) is a severe malformation of the dental system, which is characterized by severe structural and functional disorders. Perhaps there is no other congenital deformity that significantly changes the shape of the face and leads to such significant anatomical and functional disorders (Granchuk G.N., 1987; Makhkamov E.U. et al., 1987; Medvedev M.V., 2001; Amanullaev R.A. et al., 2013).

**Introduction.** The priority in the surgical treatment of cleft lip and palate is to restore the correct relationship of the anatomical structures, which contributes to the earlier rehabilitation of patients (Davydov B.N., 1999; Medvedeva M.A., 2007; Mamedov Ad.A., 1995-2012). In recent years, effective methods have been developed to eliminate cleft lip.

Treatment of patients with congenital cleft lip and palate begins from the first days of life and continues for many years. In the treatment of such patients, the active participation of many specialists is required: maxillofacial surgeon, orthodontist, therapist, speech therapist, otorhinolaryngologist (Kislykh F.I., 2007; Lavrikov V.G., 2007).

GV Gonchakov (2002) believes that the treatment of children with congenital cleft lip and palate is one of the most difficult tasks of pediatric reconstructive surgery, the solution of which is not limited to the elimination of a cosmetic defect and the reconstruction of facial proportions close to the norm.

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World experience in the treatment of patients with CCLP has led to the possibility of good results in surgical correction of both primary defects and secondary deformities. At the same time, the existence of such issues as: the optimal age of the child when performing primary surgical correction, the choice of the most functionally optimal and least traumatic method, the cumulative effect of these factors on the subsequent state of hearing, speech, growth of the upper jaw and middle zone of the face, and the general development of the child, remain controversial, and are widely discussed in domestic and foreign literature. At the same time, it is obvious that it is the timely and correct implementation of the first stage of surgical treatment that determines the success of the rehabilitation of patients with congenital cleft lip and palate (Makhkamov E.U.1998). According to I. A. Kozin (1996), it is hardly possible to find a branch of surgery that, in terms of the number of proposed methods of surgical intervention, surpassed the surgical treatment of congenital facial

clefts. Along with great achievements in surgery for congenital cleft lip, the results of surgical interventions do not fully satisfy both patients, their parents, and surgeons.

Surgical treatment of congenital bilateral clefts occupies a special place in its relevance, variety of surgical methods and many unresolved issues. Among the wide variety of methods of primary plasty of congenital cleft lip and palate, there is currently no preference for any one technique. The use of new methods of surgical treatment is not always rational and does not make it possible to fully rehabilitate a child with this pathology (Kozin I. A., 1996).

Currently, there is a clear trend towards early upper lip plasty. This approach reduces the period of maladaptation of the child, reduces or eliminates the "burden" of disability, creates equal conditions in all areas of the child's later life, which is very important. Any variant of upper lip plasty is one of the most complex reconstructive and restorative operations that require special training of the surgeon, provision of appropriate anesthesia and postoperative care. There is also an opinion about early, sparing operations in the scope of primary cheilorhinoplasty (B.N. Davydov, 2000). According to these authors, the number of children in need of secondary rhinocheiloplasty is subsequently significantly reduced. Therefore, the current trend can be defined as the expansion of the scope of surgical intervention, its implementation in a gentle manner and at an early age.

Any variant of reconstructive surgery on the upper lip with any cleft variant can be performed from the birth of a child, but the intervention must be justified by social indications. Starting from 3-6 months and until the end of the first year of life, cheiloplasty should be performed in full.

With congenital bilateral cleft, anatomical disorders are characterized by deeper changes due to the presence of three fragments of the lip, splitting of the alveolar part into three fragments, and unstable anterior and downward displacement of the middle fragment. The choice of cheiloplasty method, its implementation in one or two stages depends on the depth of anatomical changes. Without denying the possibility of one-stage treatment, including the technique of primary rhinocheiloplasty (Shcheglova A.P., 1997; Davydov B.N., 2006), it is believed that the grounds for two-stage treatment are the presence of a wide cleft on each side.

There are many techniques for cheiloplasty of both unilateral and bilateral nonunions (S. Tennyson, S. Hagedorn, A. Le Mesurier, A.A. Limberg, L.M. Obukhova, D. Millard, K. Kobus, L.V. Kharkova -L.N. Yakovenko). They are divided depending on the cutting of fabrics into Z-shaped, linear, rectangular. But all of them have the same goal - to restore the anatomical integrity of the elements of the lip (red border, columns, nasal passage, muscles, vestibule of the oral cavity) and its functional viability. In most countries of the world, the patchwork method of operation developed by L.M. Obukhova (1957) and C.W. Tennison (1953, 1959). These methods make it possible to compare the tissues of the lip in full anatomical correspondence and obtain a symmetrical shape of Cupid's bow. The linear methods of Limberg, Millard differ in the way the base of the nasal opening is formed with complete cleft lip. The positive side of these methods is the cosmeticity of the scar line, which coincides with the border of the filtrum. However, these methods do not allow to obtain sufficient elongation of the lips, which is necessary for wide complete clefts.

**CONCLUSION:** The choice of the method of primary cheiloplasty for congenital bilateral cleft lip and palate should be determined taking into account the degree of underdevelopment of the soft tissues of the median fragment. With underdevelopment of the median fragment by 1/3 or 1/2 of its height, the linear methods of Millard and Limberg are highly effective. At the same time, the main elements of the upper lip are restored, less noticeable postoperative scars are observed. Properly performed linear cheiloplasty with maximum tissue preservation in most cases makes it possible to restore all elements of the upper lip and nose and improve their functionality during final operations in adult patients. With underdevelopment of the soft tissues of the median fragment by 2/3 of its height, when a pronounced shortening of the upper lip is observed, the Obukhova-Tennyson method makes it possible not only to restore the elements of the upper lip and the base of the wing of the nose, but also to normalize the mobility of the circular muscle with the formation of myodynamic balance.

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