



Short Communication

Volume 9 Issue 5 - May 2020
DOI: 10.19080/AJPN.2020.09.555827

Acad J Ped Neonatol

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Clinical Aspects in a Multidisciplinary Cleft Lip and Palate Prenatal Visit



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Submission: May 22, 2020 **Published:** May 26, 2020

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Keywords: Down syndrome; Palate-craniofacial; Interdisciplinary; Trusting; Pediatrics; Congenital; Pediatrician; Otolaryngologist; Geneticist; Orthodontist; Audiologist; Maxillofacial; Psychologist; Population; Therapist; Networking; Consultation; Maternal; Abnormal; Pregnant

Short Communication

Cleft lip and/or palate (CL/P) is the second most common congenital birth defect in the United States (1:600 births) trailing only Down syndrome. The American Academy of Pediatrics (AAP) strongly recommends a prenatal visit with a pediatrician for all expectant families and especially in high-risk clinical conditions that may require special care [1]. In general, prenatal visits allow establishing a supportive and trusting relationship with the parents, collect information, provide anticipatory guidance, and enhance parental skills. In unison, the American Cleft Palate-Craniofacial Association (ACPA) recognizes that a prenatal interdisciplinary visit will offer a valuable opportunity to create a personal relationship between the parents and the care team. During your prenatal counseling visit, expecting parents will meet with providers from the CL/P team. Our model on compliance with the current standards for the treatment of orofacial clefts, includes a craniofacial surgeon, a maxillofacial surgeon, a pediatrician, a geneticist, an otolaryngologist, a pediatric dentist, an orthodontist, an audiologist, a speech therapist, a child psychologist and a social worker, all group members skilled in the management of this complex patient population. In our large academic center, the Maternal-Fetal Medicine Fellows will be a future asset to our team. Throughout this initial consultation, we provide an individualized surgical time and explain the concept of team care. Families who are new to cleft and craniofacial care often benefit from hearing others' experiences, so we facilitate parental networking and offer educational resources. In our practice, it has become a habit to provide a list of websites including or own to obtain trustworthy information and advice. The ultimate objectives of this coordinated interdisciplinary session are to establish a "Team-Family" strong

relationship and to identify high-risk issues (e.g. Adolescent parent) to be address in future visits.

Prenatal Imaging Informed Consent

Informed consent on how deliver the antenatal ultrasound imaging findings to parents will become a complicated ethical and moral issue. Pregnant women who want to test their fetuses prenatally should be able to do so, but they should only be offered testing as part of a process of exploring their goals and values for parenting and family. A family who has already been guided to have fetal routine medical care may have difficulty in realizing the testing as a preamble to a decision about what kind of child they are willing to parent. Certainly, abnormal results could have a definitive impact on the decision making to opt for termination of pregnancy. From a different perspective, current mainstream medical opinion is that the child's right not to know should be respected in the case of serious late-onset disease. This debate around the ethical challenges of related comprehensive genetic testing is presently conducted in the contexts of neonatal screening and invasive prenatal evaluation.

Prenatal Diagnosis

These days, cleft lip with or without palate (CL/P) could be identified on a routine prenatal ultrasound due to significant improvement in technological advances. Cleft lip can be detected by ultrasound as early as 12th week into the pregnancy, but as the fetus continues to develop, the sensitivity of the test significantly increases after the 20th week of gestation. It is important to remark that antenatal detection rates are variable ranging from

9% to 100% for cleft lip with or without palate and from 0% to 22% in cleft palate only [2,3]. Shadowing from the bony maxilla and alveolus usually impedes a clear view of the hard palate when using a standard two-dimensional (2D) ultrasound device. Consequently, isolated cleft palate often become overlooked until birth physical examination. In current practice, an axial three-dimensional (3D) ultrasound is obtained to identify cleft palate (high specificity >90%) when cleft lip is diagnosed at mid-trimester 2D ultrasound screening [4].

Influence in Termination of Pregnancy Decision

There is controversy whether early diagnosis of cleft lip or palate would lead to an increased rate of pregnancy termination, which presents moral and ethical dilemmas. Literature review revealed remarkable socio-cultural differences on the perception and attitude toward termination of pregnancy in the case of antenatal orofacial cleft detection. In large parental surveys in the Argentina and Netherlands none of the responders chose to terminate the pregnancy and only a minority considered if other anomalies were found (e.g. Down syndrome) [5,6]. Contrasting reports from Israel and Taiwan where expecting mothers decided pregnancy termination (90% and 53% respectively) after they receive their prenatal diagnosis [7]. Our center believes that an interdisciplinary team counseling approach is the best way to provide parental comprehensive clinical information to prepare them for the future decision-making. The establishment of a mutual commitment to a goal and rewarding family-team relationship usually results from the team visit.

Prenatal Counseling

Families notified about oral cleft malformation at birth often experience a psychosocial stress that characterizes by disappointment, helplessness, and desperation, which may lead to a period of severe emotional crisis. Parents who possessed prenatal knowledge of their child's diagnosis of CL/P displayed an overall decrease in negative emotions and a reduction in concerns. The role of prenatal diagnosis and prompt counseling has become a key to alleviate the distressful emotional response of giving birth a child with orofacial clefts. If there are, other children in

the family, our pediatrician and psychologist can provide helpful advice about managing the older sibling's adjustment. Medical professionals should be prudent about their positive or negative influence on parents' decision.

Insurance Reimbursement

Prenatal visit reimbursement it is a challenge even with a formal obstetric referral. It would be advisable to seek advocacy from AAP coding resources when facing insurance coverage problems. Networking with other craniofacial teams might be of benefit to establish uniform compensation strategies.

In synopsis, a craniofacial multidisciplinary team is the standard of care and the foundation of management of cleft patients. This expert team will provide factual clinical information and psychological counseling making the pregnancy and delivery of an infant with a cleft a positive experience.

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DOI: [10.19080/AJPN.2020.09.555827](https://doi.org/10.19080/AJPN.2020.09.555827)

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