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IP Journal of Otorhinolaryngology and Allied Science

Journal homepage: https://www.joas.co.in/

Case Report

Devil's bite in an adult woman: Unheeded & overlooked

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ARTICLE INFO

Article history:
Received 19-02-2022
Accepted 10-03-2022
Available online 16-04-2022

Keywords:
Cleft Palate
Gestational
Birth Defects
Orofacial Clefts
Oro-Facial Clefts

ABSTRACT

Cleft lip and cleft palate are birth defects that occur when a baby's lip or mouth does not form properly during pregnancy. Together, these birth defects are commonly called "Oro-facial clefts". Cleft palate alone can often have problems with feed, speech & hearing and problems with teeth development. The causes of these clefts among most infants are unknown. Cleft lip and cleft palate in a child are thought to be caused by a combination of genes and other factors during their gestational development.

1. Introduction

Cleft lip and palate are the most common congenital craniofacial anomalies treated by a collaborative multidisciplinary approach and team. There are multiple set of problems associated with oro-facial cleft such as: problems with feeding, swallowing, dental, nasal deformity and aesthetics, ear and hearing, speech and associated anomalies. The successful treatment of these children with any of the above mentioned symptomatology requires coordinated care from multiple specialities at different stages of life starting from infancy up to adulthood to optimize treatment outcome. The goal of cleft care is to eliminate as many steps in the treatment plan as possible by optimizing the outcome and benefit of each essential intervention, as a child with a cleft needs a complex lengthy surgical treatment plan.

2. Case Report

During one of the visits to a medical camp, this adult female was incidentally encountered having Cleft palate with uvula. She had ignored this condition since the time she came across this and noticed it. She had actually come for consultation for decreased hearing. This was noticed during routine clinical examination of ear, nose and throat. She had difficulty in speech, nasal regurgitation while having solids/liquids and hearing problems. She had consulted now for having decreased hearing. On oral cavity examination, midline split was seen involving both the hard and soft palate also including the uvula (incomplete cleft: Veau Group II classification). She was asked as to the reason behind the ignorance. She said that her family neglected this during her childhood due to financial constraints mainly and also partly due to lack of awareness about management. Hence, she has been dealing with it and imbibed it as part of her being. She even said that at present she feels there is no need for any surgical intervention regarding this. This case report is submitted so as to throw light on focussing the need of intervention of orofacial clefts and not to be neglected, overlooked upon just as mere "devil's bite"- part of vicious circle of social stigma wherein the life of an individual is way beyond such irrational social taboos. In the present day, enhancing the persona is by having a decent outlook, pleasant smile and appropriate comprehension skills, which are the quick attention seeking abilities to impress and

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https://doi.org/10.18231/j.ijoas.2022.006

influence their presence in society. Hence, these orofacial clefts play a major role of hindrance to these assets so as to have a normal development and respectable lifestyle.

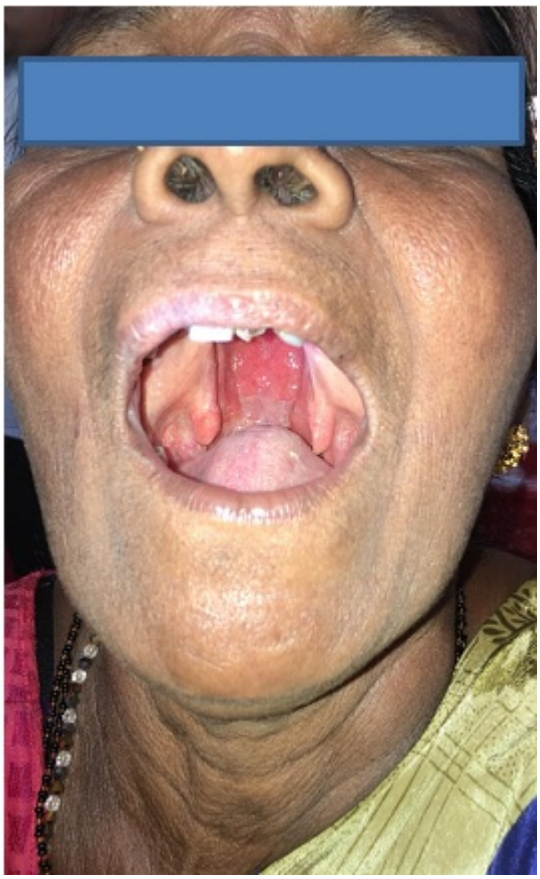

Fig. 1: Midline cleft involving both hard and soft palate including the uvula.

3. Discussion

Cleft lip and palate is the second most common congenital craniofacial anomaly after clubfoot. Among 15 types of orofacial clefting, cleft lip and palate is the most common one. Cleft care requires participation of collaborative multidisciplinary approach and team. Successful treatment of these children needs triad factors: technical skills, in-depth knowledge of the abnormal anatomy and appreciation of 3-D facial aesthetics.[1] There was no mention of cleft palate by Hippocrates (400BC) and Galen (150AD). Cleft palate was first identified by Fanco in 1556 and first successful closure of soft palate defect was reported in 1764 by LeMonnier. Its incidence globally is 1.7 lacs before and 35,000 now while in India 28 lacs children with adults are living with cleft and 10lacs are untreated cases. Mostly untreated cases are due to lack of awareness that surgical treatment is possible or financial constraint. Epidemiology: The recorded worldwide cases are 1:600. Cleft lip with or without cleft palate is 9.92/10,000 and cleft lip alone 3.28/10,000 and cleft lip and palate 6.64/10,000. Birth prevalence of the clefts is between 27,000 and 33,000 clefts per year. As per WHO study published in 2001, a child is born with a cleft somewhere in the world every 2 minutes.[2] The more common clefts are: U/L clefts, M: F= 2:1 and usually left-sided clefts. Males are more affected by cleft lip and females more affected by cleft palate. The most common diagnosis is cleft lip and palate at 46%. The cases of Isolated cleft palate is 33% and isolated cleft lip is 21%. Majority of bilateral cleft lips (86%) and unilateral cleft lips(68%) are associated with cleft palate. In white population, cleft lip with or without cleft palate occurs in approximately 1 in 1000 live births. This is twice as common in the Asian population and half as common in African Americans.[2] The development of palate occurs at 2 different stages of embryonic origin: Primary palate- it is the triangular part of the hard palate anterior to incisive foramen which originates from pre-maxilla (fronto-nasal prominence) which develops at 4^{th} and 8^{th} week of gestation. Secondary palate- remaining part of the hard palate and all of the soft palate posterior to incisor foramen which comes from palatine shelves of the maxillary prominences which develops between 8^{th} and 12^{th} week of gestation. There are also various theories implicated for its development (embryological background), which are: alteration in intrinsic palatal shelf force, failure of tongue to drop down, non-fusion of shelves and rupture of the cyst formed at the site of fusion.[3] There is a wide spectrum of etiopathogenesis that ranges from environmental teratogens to genetic factors with regards to genesis of cleft lip and palate. “Actually no one knows the exact cause for clefts”. Genetics (inherited characteristics) from one or both parents, Intrauterine exposure to phenytoin (anticonvulsant) has a 10 fold increase in incidence of cleft lip, risk with corticosteroids (anti-inflammatory), retinoids, Infections like Rubella during pregnancy, alcohol consumption, smoking, hypoxia during pregnancy, some of the dietary and vitamin deficiency(like folic acid and vitamin A deficiency), maternal smoking during pregnancy doubles the incidence of cleft lip, increase maternal age, Genetic abnormalities can result in syndromes that include clefts of primary or secondary palate and the most common syndrome associated with cleft lip and palate is Van der Woude’s syndrome while others are: Stickler syndrome, Velocardiofacial syndrome(Shprintzen’s), Treacher-Collin syndrome. DiGeorge or Conotruncal anomaly syndrome are the most common diagnosis associated with isolated cleft palate. Pierre Robin sequence is the most common associated non-syndromic anomaly.[1–5] The problems associated with cleft lip and palate are difficulty in feeding, dental problems, nasal deformity and aesthetic problems, ear problems, speech difficulties and associated anomalies as referred above. The treatment planning sequence begins

from the prenatal period and lasts upto the age of 20 years. Hence, this needs patience and cooperation from the parents towards the development and well-being of their child for the future.[6] Orofacial clefts are the second most common congenital anomaly having multifactorial origin. A considerable knowledge about the etiology and embryology is required for proper diagnosis and treatment of such patients. Treatment protocols begins soon after birth and continues till adulthood requiring a team approach, which is not the focus in this case report.

4. Conclusion

Cleft palate and lip, are birth defects that can be surgically closed within a very early age of life if consulted at the right time. Certain things such as: swallow/feed, speech and hearing are important basic amenities for a being that need to be regulated at the initial stage of life once encountered as they cannot and should not be compromised. Witlessness, Obliviousness, Unawareness are to be left behind when it comes to improvement and development of self in the best way possible with available facilities which the medical field has accomplished for orofacial defect closure. Also the psychosocial aspects with regards to orofacial defects has to be tackled in a very mature and realistic manner such that self-assurance, self-belief, self-confidence and self-reliance must not be hindered but instead risen up which can take a toll in overall development of a personality. This “harelip” is no longer doomed to be a curse to mankind, when such condition can be repaired, restored and renovated and has a positive impact on quality of life.

References

1. Dixon MJ, Marazita ML, Beaty TH, Murray JC. Cleft lip and palate: synthesizing genetic and environmental influences. *Nat Rev Genet*. 2011;12(3):167–78. doi:10.1038/nrg2933.
2. Eckstein DA, Wu RL, Akinbiyi T, Silver L, Taub PJ. Measuring quality of life in cleft lip and palate patients: currently available patient-reported outcomes measures. *Plast Reconstr Surg*. 2011;128(5):518–26. doi:10.1097/PRS.0b013e31822b6a67.
3. Mossey PA, Little J, Munger RG, Dixon MJ, Shaw WC. Cleft lip and palate. *Lancet*. 2009;374(9703):1773–85. doi:10.1016/S0140-6736(09)60695-4.
4. Wehby GL, Cassell CH. The impact of orofacial clefts on quality of life and healthcare use and costs. *Oral Dis*. 2010;16(1):3–10. doi:10.1111/j.1601-0825.2009.01588.x.
5. Patrick DL, Topolski TD, Edwards TC, Aspinall CL, Kapp-Simon KA, Rumsey NJ, et al. Measuring the quality of life of youth with facial differences. *Cleft Palate Craniofac J*. 2007;44(5):538–47. doi:10.1597/06-072.1.
6. Marcusson A, Akerlind I, full-text PDF Read full-text Download citation Copy link Citations (116) References (96) D. Quality of life in adults with repaired complete cleft lip and palate. *Cleft Palate Carniofac J*. 2001;38(4):379–85. doi:10.1597/1545-1569(2001)038<0379:QOLIAW>2.0.CO;2.

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Cite this article: Basavannaiah S. Devil’s bite in an adult woman: Unheeded & overlooked. *IP J Otorhinolaryngol Allied Sci* 2022;5(1):21-23.