



A child born with a cleft frequently requires several different types of services, e.g., surgery, dental, orthodontic care, and speech therapy - all of which need to be provided in a coordinated manner over a period of years. This coordinated care is provided by interdisciplinary cleft palate/craniofacial team comprised of professionals from a variety of health care disciplines who work together on the child's total rehabilitation. A child with a cleft lip/palate requires the same regular preventive and restorative care as the child without a cleft. However, since children with clefts may have special problems related to missing, malformed, or malpositioned teeth, they require early evaluation by a dentist who is familiar with the needs of the child with a cleft.

Orthodontic care is given to achieve the best esthetics, function, and stability of a child's bite. This treatment may include traditional braces, orthopedic appliances designed to influence jaw growth, or simple removable appliances. Since facial growth is an important aspect of orthodontic care, the first orthodontic evaluation may take place even before the child has any teeth. As the baby teeth and later, the permanent teeth begin to erupt, the orthodontist monitors the child's dental and facial development, and intervenes with treatment when necessary. Thus, it is not unusual for a child with a cleft to have two or even three carefully planned phases of treatment. Each phase will have specific goals, and in between phases, appliances may be removed. Orthodontic care must be carefully coordinated with any surgical or prosthodontic care to achieve optimal results.

Orthodontic and Surgical Care

Coordination between the surgeon and the orthodontist becomes most important in the management of the bony defect in the upper jaw that may result from the cleft. Reconstruction of the cleft defect may be accomplished with a bone graft performed by the surgeon. Prior to surgery, the patient may receive an expansion appliance in preparation of any necessary gains in upper jaw width. A retainer is then usually worn to hold the width of the upper jaw until full braces are applied at a later stage.

When the child approaches adolescence, the orthodontist and the surgeon may again coordinate their efforts if the teeth do not meet properly when the jaws are in abnormal positions front to back. In the case that tooth relations cannot be made normal by orthodontics alone, a combined approach of both orthodontics and surgical repositioning of the jaws is necessary. Such surgery is usually performed after the pubertal growth spurt is completed.

Birth- 5 months Presurgical orthopedics

5-24 months Parent teaching regarding oral hygiene, dental development and future treatment plans; monitor eruption of teeth and dental hygiene by pediatric dentist

2-5 years Orthodontic dental records (x-rays, photos) at 4-5 years of age in preparation for evaluation of teeth and cleft size
 Monitor dental hygiene; provide appropriate preventive and restorative care
 Orthodontic records as needed to determine timing of bone graft
 Assist with speech prosthesis, as needed

6-11 years Positioning of upper jaw segments with expansion appliance in preparation for alveolar bone graft
 Recommend extractions as needed
 Monitor dental hygiene; provide appropriate preventive and restorative care
 Assist with speech prosthesis as needed
 Monitor growth; maxillary protraction as needed

12-21 years Dental records to monitor jaw growth, dental development and bone graft
 Braces for dental alignment as needed
 If upper jaw is severely retrusive, combination of jaw surgery and braces is needed
 Prosthetic replacement of missing teeth as needed
 Monitor dental hygiene; provide appropriate preventive and restorative care

If you have any questions regarding your child's treatment, please call us at (314) 4-BRACES