Cleft Palate Speech and Feeding

Train the Trainer
Module 1.1:

- Anatomy & Physiology
- Why is Speech Therapy Important?
- Embryological Development

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Typical Embryological Development

- **Lips and alveolus**
  - Begins around 6-7 weeks of gestation
  - Starts at incisive foramen

- **Hard palate**
  - Begins at 8-9 weeks of gestation

- **Velum and uvula**
  - Complete at 12 weeks of gestation
What does typical anatomy of the oral structures look like?

- Dental arch
- Premaxilla
- Incisive foramen
- Palatine process of maxilla
- Palatine bone
- Posterior nasal spine
- Palatine foramen
- Hamulus
- Tensor veli palatini
- Levator veli palatini
- Uvula
An illustration of the muscles involved in velopharyngeal closure
What does typical anatomy of the oral structures look like?
What does typical anatomy of the oral structures look like?

- Nasal aperture
- Columella
- Nares
- Philtrum
- Cupid’s bow
How do the oral structures develop?

The incisive foramen is a point of embryological development. From this location the premaxilla closes on the right side and left side forward to the lip. The palate then closes from the incisive foramen back to the uvula. When one point of development does not close, this results in the cleft.
Typical hard and soft palate
Your turn!

Turn to your partner and, with a flashlight, examine his/her oral structures.

Check the color of the oral tissues, and be sure to identify the:

- Hard palate
- Soft palate
- Uvula
Module 1.2:

● Anatomy & Physiology of Different Types of Clefts

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Unilateral Cleft Lip

Mugisha, a child with a unilateral cleft lip from Rwanda.
This photo shows that the lip did not finish closing, resulting in a right complete unilateral cleft of the lip. It is complete because it extends into the nostril/nares.
Andrea, a child with a bilateral cleft lip. Before and after surgery.
Here we see that both sides did not close, resulting in this bilateral complete cleft of the lip.
One can have both a bilateral complete cleft of the lip and a cleft of the palate as well, meaning that during embryological development no closure occurred.
What does typical anatomy of the oral structures look like?

- Tensor veli palatini
- Levator veli palatini
- Dental arch
- Premaxilla
- Incisive foramen
- Palatine process of maxilla
- Palatine bone
- Posterior nasal spine
- Palatine foramen
- Hamulus
- Tensor veli palatini
- Levator veli palatini
- Uvula
Here we see that the premaxilla is protruded, which typically contains teeth buds.
The bulging premaxilla results from incomplete closure of the seams anterior to the incisive foramen. If the seams had closed during development, the premaxilla would be correctly placed.

An analogy for the development of a cleft
Types of Cleft Lip Deformities

- Unilateral (one side)
- Bilateral (two sides)
- Complete (cleft to the nose)
- Incomplete (Only a cleft of the lip. The nose is not impacted)

Clinical Questions

Ask yourself: Is one side affected, or both? (Unilateral or bilateral)

Ask yourself: Does the cleft go up to the nose? (Complete or incomplete)
Typical Facial Anatomy
Unilateral Incomplete Cleft Lip
Unilateral Complete Cleft Lip
Bilateral Complete Cleft Lip
Cleft Palate Classification

- Normal Palate
- Submucous Cleft
- Unilateral Complete
- Bilateral Complete

We will discuss this later!
Turn to your partner and discuss:
What happened during embryological development that would result in this kind of a cleft?
This is a cleft of the hard palate. It formed during embryological development due to an interruption to closure of the palate from the incisive foramen back to the uvula.
We can see a cleft of just the soft palate (left) or a cleft of the hard and soft palate (right), depending on the point at which development is interrupted.
Your turn!

Describe the type of cleft you see in the following photos and think about why this might have occurred during development.
Answer: Cleft of the hard and soft palate
Answer: Bilateral cleft of the lip with bulging premaxilla
**Answer:** Left unilateral complete cleft of the lip
Answer: Unilateral complete cleft lip with a bulging premaxilla and erupted tooth
Module 1.3:

- Submucous and Occult Clefts

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Three characteristics of a submucous cleft

- Bifid uvula
- Zona pellucida
- Notch in posterior border of the hard palate
Submucous Cleft

- **Zona pellucida**
  - Bluish area in the middle of the velum.
    - Bluish coloring
    - Caused by thin mucosa
    - Lack of normal underlying muscle mass
  - Velum may appear to be in an inverted “V”, especially during phonation.
    - “V” shape
    - Abnormal insertion of the veli palatini muscles in the posterior section of the hard palate
    - With phonation, velum appears to “tent up” toward hard palate.
Submucous Cleft - Zona pellucida
Submucous Cleft - “Inverted V”
Submucous Cleft - “Inverted V”
Submucous Cleft -- Bifid Uvula

❖ May be split down the middle with two pendulous structures
❖ May appear as one structure with line down the center
❖ May have a simple indentation at the posterior border
❖ Uvula may appear small and undeveloped--hypoplastic.
Submucous Cleft -- Bifid Uvula

In this photo, we see that there is a submucous cleft with a bifid uvula, as this did not close in development. Submucous cleft is not always identified because patients are not always symptomatic and, even with physical signs of submucous cleft, can have normal speech!
Submucous Cleft -- Bifid Uvula
Submucous Cleft --
Notch in Posterior Border of Hard Palate

- In normal palate, can often feel slight projection of posterior nasal spine.
- If there is an appreciable notch in the posterior border of the hard palate, this indicates the presence of a submucous cleft palate.
- Use gloved examination. Notch can be small and narrow so use pinky finger to feel.
Occult Cleft

- Sometimes children may seem hypernasal, however, there is no physical abnormality in the palate.

- Occult cleft are diagnosed through nasoendoscopy, which is when a scope with a camera is passed through the nostrils to observe how velopharyngeal structures move during speech.
Module 1.4: 

- Velopharyngeal Closure

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Muscles Involved in Velopharyngeal Closure

- **Levator veli palatini** - main muscle for velar elevation
- **Superior pharyngeal constrictor** - medial displacement of lateral pharyngeal walls
- **Musculus uvulae** - contracts during phonation and create bulge on velum which adds stiffness of velum
- **Palatoglossus muscles** - depresses the velum

*Tensor veli palatini* - opens the Eustachian tube for middle ear drainage, contributes little or nothing with velopharyngeal closure.
Remember what typical anatomy of the oral structures looks like:

- Dental arch
- Premaxilla
- Incisive foramen
- Palatine process of maxilla
- Palatine bone
- Posterior nasal spine
- Palatine foramen
- Hamulus
- Tensor palatini muscle
- Levator Veli Palatini
- Uvula
The levator veli palatini muscle cannot connect where there is a cleft palate, meaning that the soft palate cannot raise appropriately to create high pressure oral sounds.
The Door Metaphor is an analogy for better understanding cleft palate and why speech errors occur.

Play Video #1 entitled “Door Metaphor for Velopharyngeal Closure”
Turn to your partner and practice reciting **The Door Metaphor**. This will be necessary when explaining cleft palate airflow and speech to parents of children with cleft palate.

Your turn!
Velopharyngeal Closure Patterns

There are 4 typical ways velopharyngeal closure can occur. These are different ways in which “the door” can close to create high pressure oral sounds, such as “p”, “b”, “t”, “d”, “k”, “g”, “f”, “s”, “z”, “ch”, “sh”, etc.

- **A. Coronal** closure pattern, superior movement of the soft palate is the main contributor to VPC.
- **B. Sagittal** closure pattern, movement of the lateral pharyngeal walls is the main contributor to VPC.
- **C. Circular** closure pattern, movement of the lateral pharyngeal walls and SP contribute equally to VPC.
- **D. Circular with Passavant’s Ridge** “Passavant’s Ridge” is a bulge of tissue on the posterior pharyngeal wall that aids in VPC.

**Abbreviations:**
- PPW = Posterior pharyngeal wall
- RLW = Right lateral pharyngeal wall
- LLW = Left lateral pharyngeal wall
- SP = Soft palate
- VPC = Velopharyngeal closure
What is *velopharyngeal dysfunction* (VPD)?

Condition where the door--the velopharyngeal closure--does not happen. Why?

**Structural** - “VP insufficiency”
- Velum too short to reach the posterior pharyngeal wall
- Hole in the palate--a cleft palate--that is a structural reason why the door cannot close

**Functional** - “VP incompetency”
- Physiological: The levator veli palatini does not do its job of lifting the soft palate
- Neurological: Apraxia, dysarthria, brainstem tumor
Examples of velopharyngeal insufficiency include a cleft, submucous cleft, or short velum. This picture shows a short velum, which would be a structural deficit resulting in velopharyngeal insufficiency.
What is “velopharyngeal mislearning”? 

- **Articulation disorder** that might seem like velopharyngeal dysfunction
  - Normal structure, normal function

- Air exits through the nose for high pressure sounds
  - /p/ /b/ /t/ /d/ /k/ /g/
  - Continuous sounds (e.g. /f/ /sh/ or /s/) are hypernasal
Module 1.5:

- Feeding a Baby with Cleft Palate (Abbreviated)

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Strategies for feeding a baby with cleft lip or palate

1. Always feed your baby in an upright position, whether it is from the breast or cup.

2. Burp your baby every 5 minutes.

3. Keep your baby upright or seated for 20 – 30 minutes after each meal.
Strategies for feeding a baby with cleft lip or palate

For more information on feeding a baby with cleft lip and palate, see Optional Presentation “Feeding a Baby with a Cleft Lip and/or Palate”
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Support and Funding Provided By:

- The Wyncote Foundation
- Smile Train
- Teachers College, Columbia University
- The Crowley Family

Special thanks to the families and children in these videos
Cite this as:


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 Discrimination Clown Picture
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Kummer, A. (n.d.). Speech therapy for cleft palate or velopharyngeal dysfunction (VPD). *Cincinnati Children’s Hospital Medical Center*, 1-6.


References


