South Australian Perinatal Practice Guidelines

Management of cleft lip and palate in the neonatal period

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Management of cleft lip and/or palate in the neonatal period flow chart

Baby born with a cleft lip and/or palate

Medical or neonatal nurse practitioner assessment as soon as practical after birth

Cleft lip and/or palate the only problem

- Room-in with mother. Transfer to a neonatal nursery is not required
- Establish maternal feeding preference
- Refer to cleft plastic surgeon, cleft feeding specialist (speech pathologist or a member of the nursing team with cleft training), and
- Cleft feeding specialist to assess as soon as practical and within 24 hours of birth
- Cleft feeding specialist directs feeding plan

Other issues identified

- No in-house expertise on cleft feeding management (speech pathology or trained nursing staff)
- Airway concerns (Pierre-Robin sequence)
- Prematurity
- Birth weight <2500g
- Other major anomalies

Admit to a Level 5 or 6 neonatal nursery for individualised management

Maternal preference for breast feeding

- Management before feeding assessment
 - Suggested minimum
 - length of stay 5 days Feeds and observations follow normal postnatal ward procedure including putting baby to the breast as soon as practical
 - Commence breast expression as soon as practical for EBM top-ups after breast feeds
- Feed with a 4 hour limit
- Give top-up feeds of expressed colostrum (at the volume available) or formula (5mL) by finger feed routinely post breast feeds
- No bottles offered until feeding assessment by cleft feeding specialist
- Management subsequent to feeding assessment
- Feeding is either by breast with full EBM bottle top-ups, or solely bottled EBM, as mutually agreed by parents, lactation consultant and cleft feeding specialist
- Use a squeeze bottle and teat
- Offer bottled EBM at the volumes that can be expressed: monitor weight gain

Maternal preference for formula feeding

- Management before feeding assessment
- Suggested minimum length of stay 5 days
- Feeds and observations follow normal postnatal ward procedures
- Finger feeding is commenced giving 5mL of formula per feed
- No bottles offered until there has been a feeding assessment by a cleft feeding specialist
- Management subsequent to feeding assessment
- A squeeze bottle and teat are used

Cleft lip (Isolated)

Cleft palate

(+/-lip)

Feeds and observations follow normal postnatal ward procedure. No special feeding interventions are required

For all uncomplicated clefts

- > Parental education in resuscitation is desirable
- > Outpatient Cleft Palate Clinic and Audiology follow-up is required
- > Paediatrician follow-up is recommended



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Important points

- > Cleft lip and / or palate occurs in approximately 1 per 800 births in South Australia
- > Antenatal diagnosis of cleft lip is usually possible; however isolated cleft palate is usually not seen with morphology ultrasound
- Where there is an antenatal diagnosis of cleft lip, antenatal counselling should occur through a plastic surgeon experienced in cleft lip and palate surgery, and with a practitioner experienced in cleft feeding management.
- Babies born with a cleft may present with a range of feeding difficulties according to the type and severity of the cleft. Mode of feeding (breast milk or formula) should be discussed where possible in the antenatal period.
- > Following birth, babies should have a medical assessment to determine the nature of the cleft and any associated abnormalities or co-morbidities.
- > In the majority of cases, the baby can be nursed safely with the mother on the postnatal ward. Transfer to a neonatal nursery and the use of naso-gastric tubes is only appropriate for those babies who have additional medical problems.
- > Isolated cleft lip generally doesn't result in significant feeding difficulties. These babies can be managed normally.
- With a cleft palate, the major difficulty is an inability to create sufficient negative intra oral pressure for effective feeding, reducing sucking efficiency.
- Breast milk feeding is encouraged. Breast milk is beneficial to all babies, and for cleft palate babies breast milk is also less irritating to the exposed nasal mucosa and gives some protection against otitis media with effusion.¹
- Where a mother wishes to breast feed, the presence of a cleft should not hinder immediate post partum suckling. However, transfer of breast milk by suckling at the breast is rarely adequate where there is a cleft palate, and the emphasis should be on maintaining lactation and providing expressed breast milk by bottle. Where there is a strong maternal desire to continue to put the baby to the breast, this can be supported by providing top-ups of EBM by bottle.
- The support of parents by cleft feeding specialists during the establishment of feeding is essential and has been shown to improve weight gain. ^{2,3,4,5,6}
- Babies usually require only small quantities of milk in the first 24 hours. Gentle finger feeding of the volume of breast milk able to be expressed, or 5 mL aliquots of formula where the intention is to formula feed, is safer than a squeeze bottle. Squeeze bottles should not be used until after a feeding assessment because an inexperienced operator may cause the baby to choke.

Neonatal management

Neonatal management is outlined on the attached Flow Chart



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Abbreviations

EBM	Expressed breast milk	
ESSR	Enlargement, stimulate, swallow, rest	
mL	Millilitre(s)	

Version control and change history

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Version	Date from	Date to	Amendment
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