CONDITION OF THE LYMPHOID-PHARYNGEAL RING AND PHARYNX IN CHILDREN WITH CONGENITAL CLEFT LIP AND PALATE

Shomurodov Kakhramon Erkinovich
Head of the maxillofacial surgery, prof., D.Sc.
Tashkent State Dental Instiute,
Makhamadaminova Shoira Abduvaliyevna
Assistant of the ENT department, D.Sc,
Tashkent Medical Academy,
Ergasheva Niginabonu Ilxomjon qizi
Scientific researcher.

Annotation. Considering the growing number of children born with congenital cleft lip and palate (CLP), the interest of doctors of various specialties in the treatment and rehabilitation of this group of patients is increasing every year. The existing algorithms for managing such patients have been developed mainly for maxillofacial surgeons and do not cover aspects related to ENT pathology

Key words: malformation, adenoid vegetation, palatine tonsils, adenoidit, hypertrophy.

The few publications devoted to the problems of children with CLP describe pronounced changes in the ENT organs. From the first days of life, the child has significant changes in the external nose, structures of the nasal cavity, middle ear and lymphoid-pharyngeal ring (LPR). ENT diseases are detected in children with this congenital defect in all periods of childhood. This fact indicates that surgical treatment of congenital defects performed by maxillofacial surgeons is insufficient and cannot fully solve the problem of ENT pathology in this group of patients.

The problem of congenital malformations of humans has been relevant in medicine for a long time. According to various authors, children born with congenital malformations make up from 1 to 12% of all newborns. However, there is a tendency to increase their number every year.

In the structure of congenital malformations, congenital pathology of the maxillofacial region, in particular, congenital rhinoplasty, occurs in 1.3-5% of cases. This pathology makes up 86.9% of all congenital facial defects and ranks second in frequency among congenital pathologies. According to the authors, the frequency of patients with this congenital pathology ranges from 1:500 to 1:1000 newborns. According to WHO, the worldwide birth rate of children with congenital pharyngeal tonsil defects is 0.6-1.6: 1000 newborns. In the Lipetsk region, the birth rate of such children was 1:566 in 2004 and 1:800 in 2003. Disability in this group of children occurs from the moment of birth, so information on the frequency of congenital pathology is important for understanding the health status of the population as a whole.

Hypertrophy of adenoid vegetations and palatine tonsils, acute and chronic adenoiditis and tonsillitis are often found in somatically healthy young children. And what is the situation in children with congenital pharyngeal tonsil defects? According to foreign literature, hypertrophy of adenoid vegetations is more common in patients with this congenital defect at an early age than in healthy children, but with age, the number of cases of diagnosis of hypertrophy of the pharyngeal tonsil becomes approximately equal.

Studies have shown that children with VRVGIN aged 2 to 16 months do not have hypertrophy of the adenoid vegetations, but there is moderate hyperemia of the pharyngeal tonsil in 100% of cases in children before palatal plastic surgery due to mechanical damage during feeding.

When examining children aged 3 to 13 years, it was found that in 78% of cases the volume of the pharyngeal tonsil occupied less than ½ the height of the vomer, and in 22% of cases - half or more. The examination showed that at this age, most children either do not have hypertrophy of adenoid vegetations or do not exceed 1-2 degrees.

There are isolated studies devoted to indications for adenotomy in children with cleft lip and palate. Given the difficulty of nasal breathing due to the curvature of the nasal septum, hypertrophy of the mucous membrane of the nasal cavity, cicatricial narrowing of the vestibule of the nose, it is obvious that even small adenoid vegetations can further complicate nasal breathing. To improve nasal breathing, it is necessary to ensure good patency of the upper respiratory tract. This can be achieved by adenotomy, but this is not always advisable in children with cleft lip and palate. There is a group of patients who develop velopharyngeal insufficiency after uranoplasty. In this case, removal of adenoids can lead to an increase in the size of the residual opening and aggravation of speech therapy problems. It turns out that, on the one hand, adenoid vegetations mechanically narrow the lumen of the airways, thereby further complicating nasal breathing, and on the other hand, they prevent the development or aggravation of clinical signs of velopharyngeal insufficiency. In this case, partial adenotomy is successfully performed. However, there are no clearly formulated indications for this operation in children with cleft lip and palate.

According to individual studies of past years, hypertrophy of the palatine tonsils occurs 2-3 times more often in children with cleft lip and palate than hypertrophy of the pharyngeal tonsil. Enlargement of the palatine tonsils is also associated with impaired nasal breathing. It was found that 1 year after uranoplasty and separation of the nasal and oral cavity, the size of the palatine tonsils remains the same.

There are works that state the fact that children with cleft lip and palate have hypertrophy of the palatine tonsils. According to the authors, hypertrophied palatine tonsils negatively affect the functioning of the soft palate and can aggravate velopharyngeal insufficiency, if any. In the presence of severe velopharyngeal insufficiency and hypertrophy of the palatine tonsils, simultaneous velopharyngoplasty and tonsillectomy are recommended. Tonsillectomy ensures better functioning of the soft palate, thereby making it possible to reduce velopharyngeal insufficiency and improve speech quality. This is quite important, since most children with cleft lip and palate develop velopharyngeal insufficiency after uranoplasty.

Conclusion. According to the literature, when studying the microflora in this group of children, gram-negative flora predominates in the oral cavity. The results of bacteriological examination of smears from the cleft area indicate the presence of Candida spp., E. coli, Klebsiella spp.

Analysis of head computed tomography data indicates that the size of the nasopharynx in children with cleft lip and palate is smaller than in healthy children, a decrease in the size of the skull base in the middle cranial fossa and the height of the sphenoid bone body was noted.

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