

ACPA STATEMENT ON CLEFT LIP/PALATE RELATED SURGERIES AND TEAM CARE DURING THE COVID-19 PANDEMIC

The American Cleft Palate-Craniofacial Association (ACPA) has prepared this statement in response to the national and institutional calls for the cessation of non-essential surgery in the wake of the COVID-19 pandemic. This guidance is intended to complement, rather than replace, existing advice and should be considered “expert opinion.” ACPA will update this statement as the situation evolves.

Because COVID-19 transmission is primarily through droplet spread, teams that perform procedures in the head and neck are at high risk for infection. Although many procedures performed by teams are important and somewhat time sensitive, this national health care crisis will cause delays. The health and safety of patients, members, trainees and hospital teams are the top priority.

All providers should first consider individual circumstances and the best interests of their unique patients, as well as the constrained resources of their institutions. Hospital, local and regional regulatory bodies will determine the actual practice in each hospital or facility, and any additional restrictions that are applied by such bodies should supersede these guidelines.

Team Care

ACPA is dedicated to the multidisciplinary team care and to optimizing outcomes for patients with cleft lip, cleft palate and/or other craniofacial differences. During the COVID-19 pandemic, it is important to maintain social distancing and minimize direct contact. Most clinics and hospitals have determined that multidisciplinary visits, feeding and speech-language evaluations are largely non-essential and can tolerate a delay.

ACPA recommends continued collaboration between team members and families while respecting the directives of social distancing

and utilizing telehealth options as resources allow. Telehealth or phone conversations with parents may be sufficient. It is also imperative that care teams proactively establish a reentry plan and prioritize patients for future evaluation and treatment.

Primary Cleft Lip Surgery

Surgeons should generally err on the side of caution and delay primary cleft lip repair. There are no studies that demonstrate a relationship between delaying primary lip repair and a negative impact on speech or feeding. If patient comorbidities, age and hospital resources permit this surgery to proceed as an outpatient procedure, then surgery could be considered on an individual basis.

The use of NAM should also be considered for each case. Because this practice requires the frequent instrumentation of the mouth and nose, appropriate PPE and hand hygiene must be utilized. “Lip taping,” nasal stents or other forms that are performed at home could be considered as an alternative, and progress could be followed via telehealth visits.

Primary Palate Surgery

Patients with a cleft palate often have difficulty with nutrition and ultimately with speech production. If possible, pursuing non-surgical options for nutrition support is encouraged. There are many alternate clinical treatments available to address nutrition and hydration for infants with unrepaired cleft palate. Telehealth or phone conversations between health care providers and parents may be sufficient to address feeding difficulties.

The physiology of Pierre Robin Sequence (PRS) can also impact breathing functions. Neonatal airway management associated with PRS is essential and could follow local protocols on a case by case basis. Tracheostomy does lead to increased

aerosolization—mandibular distraction for airway management could be discussed and encouraged.

The association between age of palatal surgery and speech is a critically important consideration under normal operations. During the present COVID-19 pandemic, the child's well-being and safety, and that of the health care providers, should always be the primary consideration. The increased risk of future VPI does not supersede the risk of COVID infections and sequelae on the patient and provider to justify urgent palate repair at this time. Cleft palate repair may be delayed.

When the ban on elective surgical procedures is lifted, sites should consider patients individually and may choose to prioritize palate repair surgery cases, starting with the oldest children first in coordination with the resources of the local environment. Teams should lead the discussion of this reentry plan. Where available, preoperative COVID testing could be employed. This may become more feasible as more supplies become available and turnaround times for results shorten.

Speech Evaluation/Revision Surgery

Procedures involving the nasal-oral mucosal region are high risk due to aerosolization of the virus which is known to be in high concentration in these areas. Consideration can be given to perceptual evaluations via telemedicine or in office visits where unique patient circumstances apply. Instrumentation of the nose with barium for video speech evaluation or via nasendoscopy is considered non-essential and could be delayed.

VPI surgery is an elective surgery that may be safely deferred for several months, and in many cases longer, without conferring significant negative impact on speech outcomes.

When the ban on elective surgical procedures is lifted, sites may choose to prioritize palate repair surgery cases before VPI surgeries in coordination with the resources of the local environment.

April 1, 2020

Cleft Lip and Nose Surgery

Revision surgery is elective. Surgeons should consider delaying these procedures to preserve hospital resources and limit potential exposure to the health care team.

Orthognathic Surgery

Orthognathic surgery may be suggested to manage occlusion, sleep apnea or appearance. Non-surgical management of sleep apnea should be fully pursued. The AO-CMF group is suggesting closed techniques for the management of facial fractures at this time. Orthognathic surgery in patients with cleft lip and palate, other than in patients with severe sleep apnea not controlled with conservative measures, is non-essential and should be delayed.

Sources

https://www.nejm.org/doi/full/10.1056/NEJMc2001737?query=featured_home
<https://www.asha.org/SLP/healthcare/SLP-Service-Delivery-Considerations-in-Health-Care-During-Coronavirus/#endoscopic>
<https://www.entnet.org/content/academy-supports-cms-offers-specific-nasal-policy>
https://aocmf3.aofoundation.org/-/media/project/aocmf/aocmf/files/covid-19/ao_cmf_covid-19_task_force_guidelines.pdf?la=en&hash=C2B89E1E6E9AB72EBF386C747D3BC74CF1009C1E
<https://www.ahns.info/wp-content/uploads/2020/03/Stanford-Commentary-for-Nasal-procedures-in-COVID-19-era.pdf> <https://www.ncbi.nlm.nih.gov/pubmed/?term=Timing+of+palatal+surgery+and+speech+outcome.+Cleft+Palate+Craniofacial+Journal%2C+45%2C+297-308>.

Editor:

John A. Giroto, MD, MBA, FAAP, FACS

Contributors:

Adriane L. Baylis, PhD, CCC-SLP
John F. Caccamese, DMD, MD, FACS
Scott A. Dailey, PhD, CCC-SLP
Allison M. Dobbie, MD
Amelia F. Drake, MD
Sean P. Edwards, MD, DDS, FRCDC
Lynn M. Fox, MA, MEd, CCC-SLP
Mary A. Hardin-Jones, PhD
Sara Kinter, MA, CCC-SLP
Jamie L. Perry, PhD, CCC-SLP
Derek M. Steinbacher, MD, DMD
Raymond Tse, MD, FRS(C)