

29. Postoperative Care

THE present primary operative plan for a bilateral cleft lip involves three procedures: (1) myringotomy, (2) soft palate closure and (3) lip closure with fork banking.

If there is also an associated cleft palate, there is certain to be fluid in the middle ears. Thus, the otolaryngologist is scheduled to carry out bilateral myringotomy and insertion of tubes for open drainage. He will follow the course of his postoperative result. If the palate is cleft but the defect is not severely wide and the soft palate elements can be brought together without relaxing incisions or severe tension, then the cleft edges are split and the nasal mucosa, muscle and oral mucosa are sutured together in three layers. Finally, the bilateral clefts of the lip are closed bringing the lateral mucosa and muscle together behind the prolabium. Unless the premaxilla was extremely protrusive or did not respond to external pressure, there should not be great tension. The forked flap will have been banked either between the lip and nose in "whisker position" or sutured in a pyramid with the alar base flaps as "praying hands." If the latter method has been used, the projections can often be coaxed to fall back into the nasal cavity or they will rise as tiny pyramids in the nasal floors. Although the appearance is odd, they do not seem to obstruct the nasal airway appreciably.

AIRWAY

At the completion of the operation the oral packing is removed and careful suction of blood from the nose, mouth and pharynx

is carried out, first by the surgeon and later through the endotracheal tube during extubation by the anesthetist. It is important to remember that the infant has been accustomed to breathing through a double cleft of the lip with the premaxilla projecting out of the way. The cleft in the palate has also presented a generous posterior airway. When suddenly the lip clefts are closed, the soft palate is closed and, to a minor degree, small tags are left in the nostril floors, there has been quite a reduction in airway.

The first postoperative precautionary measure is the placement of a 3-0 black silk *suture in the tongue* to give direct control during the early postoperative recovery from anesthesia and adjustment of the reduced airway. As soon as the infant is awake, coughing and breathing normally, this suture is simply cut and removed. As noted by F. X. Paletta of St. Louis University:

Babies with respiratory distress are placed in a hood for regulated vaporization with warm moisture and increased oxygenation.

The next postoperative consideration is *wound protection*, and this involves several aspects.



TENSION

At the end of the lip closure benzoin is painted on the cheeks and a *Logan bow* is applied with tape after the cheeks are pressed together with noticeable relaxation to the lip area. This limits some of the lateral pull against the wound from the muscles during crying and seems to be the best method of partially splinting the lip during the healing. The direct side-to-side closure of the mucosa and muscle of the lateral elements without involvement of the prolabium has taken much of the drag out of the tension. It is important, of course, that the infant not be allowed to turn over on his face as striking the Logan bow on the bed could be disastrous. When the infant is irritable and crying with straining on the wounds, then if feeding does not pacify, a suitable minimal dose of analgesic is given. *Arm restraints* to prevent flexion at the elbows, whether plaster of Paris, tongue

blade slatted wraparound splints or just large safety pins, are important. One jerk of a finger hooked in the Logan bow or the mouth could disrupt the wounds.

WOUND CARE

At the end of the operation, with the Logan bow in place and the wound open, an *antibiotic ointment* such as Cortisporin is applied to the suture lines. An order is written for this ointment to be applied three times daily after feedings. The rationale is as follows: An ointment places a protective coating over the suture holes and along the wound edges, not only preventing nasal discharge from bathing these areas but keeping local bacteria from infecting the stitch holes while the foreign body sutures are in position. The old method of scrubbing clots and debris from the suture line with hydrogen peroxide had good intention but did not prevent the crust; it merely removed it—and painfully. If a clot does form, then, of course, it should be removed. The presence of the ointment keeps the sutures soft and facilitates their *removal on the third or fourth day*.

FEEDING

Regular formula feeding by an *Asepto syringe with a rubber tube extension* is started as soon as the infant is awake and hungry. The nurse sits the patient upright with his head in her hand and slips the tube over the tongue, squeezing the amount of formula he is able to take. It is well to finish off each feeding with clear water through the tube of the Asepto to clean the palate suture line.

ANTIBIOTICS

Antibiotics are not used routinely following lip surgery. If the suture line at any time becomes even *slightly inflamed*, an antibiotic is given orally. If there is a temperature rise not accounted for by low fluid intake and even if the lungs are clear, an antibiotic is started.

HEMOGLOBIN

Surgery is not undertaken unless the hemoglobin level is above 10 gm. Bilateral cleft lip surgery ordinarily does not cause much blood loss, and even when combined with soft palate closure it rarely necessitates blood transfusion. Nonetheless, *hemoglobin study, on the first postoperative day*, is important to make certain that whatever loss was suffered has been tolerated. If the hemoglobin is severely low, a transfusion will be necessary to ensure the adequate healing; if it is moderately low, then iron in the form of Fer-In-Sol (iron drops) can be given.

DISCHARGE FROM HOSPITAL

The sutures are usually removed on the fourth postoperative day. The wounds receive their final application of antibiotic ointment to seal the suture holes. Then, as soon as the mother has been retaught to feed the baby with the Asepto syringe and feels confident to do so, she is allowed to take him home. Usually she does so on the *fifth postoperative day*, and the infant still sports a Logan bow and arm restraints. The infant is brought to the office after one week. If the tape is irritating the cheeks, the bow is removed. If not, the bow and arm restraints are removed the next week. The wounds are allowed to heal by themselves without interference with massage. There should be almost no tension on the skin wounds, and if all goes normally the scars will eventually be close to invisible.

The pyramids or whiskers of banked forks will settle into the nostril floor or sill. They must be kept clean and, although not a pair of cosmetic beauty marks, they will rest quietly until called upon to lift the nasal tip.