BILATERAL OBLIQUE FACIAL CLEFT: A CASE REPORT

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SUMMARY

A very rare case of bilateral oblique facial cleft in a 20 years old male is being reported. He had a very unusual combination of Type I & Type II ooro-ocular cleft.

Oblique facial clefts are one of the rare congenital facial anomalies. Very rarely these may be bilateral.

Khoo Boo Chai (1970) has subdivided oblique facial clefts into three subdivisions:—
   a) Naso-ocular cleft.
   b) Oro-ocular cleft:
      i) Medial (Type I)
      ii) Lateral (Type II)
   c) Mixed group.

In oro-ocular facial cleft (Type I), the cleft extends from the lip through the nasolabial region to the inner canthus or the lower lid. The fissure may extend upto the forehead. When bone is involved, the cleft begins between the lateral incisor and the canine. The cleft lies medial to the infraorbital foramen.

In oro-ocular oblique facial cleft (Type II) the fissure extends from the angle of mouth upwards to the lateral canthus or mid portion of lower lid. When the bone is involved the cleft begins between the canine and the first molar (Bicuspid teeth are absent in the primary dentition) and lies lateral to the infraorbital foramen.

In incomplete form of oblique facial clefts the central portion of the cleft which lies in the region of cheek is absent or is replaced by scar.

Treatment usually consists of one or several Z-plastics to bring the tissue into the cleft. Edges of eyelid coloboma are excised and the defect is closed (Grabb & Smith, 1979).

Case Report

A twenty years old male presented with congenital facial deformities. He had a full term normal delivery. No history of consanguinity or of such a congenital anomaly in the other siblings could be elicited.

General examination revealed bradycardia i.e. a pulse rate of 54/minute. ENT examination was within normal limits. Respiratory system and central nervous system examination revealed no abnormality.

Examination of face revealed an antimongoloid slant of right palpebral fissure, coloboma of medial one-third of the right lower eyelid (Fig. 1 & 2) and cleft in the medial portion of the right orbital margin. Epiphora was not present. Besides he had a cleft of the upper lip on the right side and another cleft at the left angle of mouth (Fig. 1 & 2). Base of ala was at a higher level on the right side. The cleft on the right side of upper lip was situated just lateral to the peak of cupids bow which was directed towards the right nasolabial groove (Fig. 1 & 2). There was no cleft in the cheek. The incomplete cleft at the left angle of mouth was ending in a small linear depression over the cheek running upwards and outwards to a distance of about 4 centimeters (Fig. 1 & 2). Lower lid on left side was normal. Maxilla was hypoplastic on either side (Fig. 3 & 4).

Intra-oral examination revealed a cleft of the alveolus on the right side between lateral
Fig. 1. Front view of the patient. Arrow indicates depression over the left side of cheek.

Fig. 2. Front view of the patient with mouth open. Arrow indicates cleft lip on the left side.

Fig. 3. Rt. lateral view of the patient.

Fig. 4.Lt. lateral view of the patient.
Fig. 5. Photograph of patient with head tilted upwards and mouth open.

Fig. 6. Photograph of the patient with mouth open after cheek and upper lip is retracted.

Fig. 7. X-ray skull (occipitomental view).

Fig. 8. Orthopantomogram showing cleft between lateral incisor and canine on the right side and canine and first premolar on the left side.
incisor and canine (Fig. 5), and on the left side between canine and first premolar (Fig. 6). Occlusion was satisfactory. There was no cleft in the palate.

Syringing revealed patent nasolacrimal duct on either side. ECG and X-ray chest showed no abnormality. X-ray skull (Fig. 7) and orthopantogram (Fig. 8) revealed a cleft in the bone medial to the infra-orbital foramen on the right side and a cleft of alveolous on left side between canine and the first premolar. The right orbit was larger and shifted downwards (Fig. 7).

**Discussion**

The medial oro-ocular clefts are due to failure of mesoderm migration or merging to obliterate the embryonic grooves between nasolateral or nasomedial prominences and the maxillary prominences, the nasomedial and nasolateral prominences having merged with each other successfully (Millard, D. R. 1977). The lateral oro-ocular cleft has the same origin as a transverse cleft, but its direction is oblique, not corresponding to any of the embryonic facial grooves (Millard, D. R. 1977).

Khoo Boo Chai (1970) in an analysis of 41 cases of oblique facial clefts, found that the ratio between incidence of oro-ocular cleft and naso-ocular cleft was 2:1. The right side was more commonly affected than the left. He could trace only seven bilateral cases in the available literature. According to Khoo Boo Chai's classification our case had incomplete medial (Type I) oro-ocular cleft on right side and incomplete lateral (Type II) oro-ocular cleft on left side with cleft in the bone on either side. Similar to the case reported in the present paper, Greer-Walker (1961) and Skoog (1969) have also reported presence of Type I and Type II oro-ocular clefts in the same patient.

On the right side cleft lip was treated satisfactorily by Randall-Tennison triangular flap method and coloboma eyelid was closed by Z-plasty. Patient was not willing for operation on the left side.

**REFERENCES**


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