Review of: "Cleft Lip and Palate Repairs in X, “Sourire de l’Espoir” Humanitarian Missions’ Experience: A Retrospective Study of 201 Consecutive Cases"

Mohammed Ahmad Hussein[1]

1 Cairo University

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"The treatment was usually limited to the primary surgery” the primary surgery is really broad word since many surgeons do primary rhinoplasties or primary bone grafting and consider it primary procedures. I guess the authors meant primary cleft lip or plate repair

I would ask, why authors adopt many different techniques for lip repair? I guess it would be a bit confusing for the trainee

Applying the Zwisch method for evaluation of trainee is a great way to standardized the training progress

Why The authors used only subjective “good and poor” parameters for assessment of results rather than using an objective parameters ? If we are talking about platalal repair we should assess plates length following repair, adequacy of muscle function, or presence of VPI. All these are important goals during repair rather than good repair or poor repair. Also the author mentioned significant fistula, that means that there were insignificant fistula, the author didn’t mention the % of these insignificant fistula.

The authors mentioned operating for mandibular fistula post-osteomyelitis, what was the cause for such condition ? What was the type of procedure done for those patients for both CLP and fistula ? Do you think it was wise to operate for CLP while there was a focus of infection in the same region? Was any complication are reported in those patients ?

The authors reported “17/201 (8.46%) patients with CP, the diagnosis was made during the growth period when the patients had started acquiring language” does the author mean that those patients had submucous cleft?

The author reported “were attributed to laryngospasm that occurred after the patients were transferred to the recovery room” what were the measures taken following these events? Why those patients didn’t get emergency tracheotomy while they are still in the OR?

I noticed long hospital stay for up to 8 days. Is there was any reasons for such long hospital stay, despite the author reported only one patient with superficial infection?

In Figure 1, despite the patient had bilateral wide cleft lip and palate , the final scar is midline scar only? Does the author scarify the premaxillary skin totally ? Also pictures of palatal repair are not for the same patient because the patient with palatal repair had intact upper arch

I have a concern about using Tennison repair in African population since the scar might be so evident such as patient in Figure 2 , I would rather prefer modified Millard operation. However I am totally agree with the author about the simplicity of the technique to be adapted by the trainee