Questions: Surgery for Cleft Palate and Velopharyngeal dysfunction (VPD)

1. The primary function of the hard and soft palate is to separate the oral cavity from the nasal passages during breathing.
   a. True.
   b. False.

2. Surgery for cleft palate results in different functional abilities for the patient. It is generally accepted that the following factors are important when determining functional outcomes:
   a. Cleft type and severity; surgical technique and age of diagnosis.
   b. Cleft palate type and severity and timing of repair.
   c. Surgical technique and surgical expertise.
   d. b and c.
   e. a and c.

3. A cleft palate presents in many different ways. Parameters include:
   a. Bifid uvula and length of the velum.
   b. Cleft of the primary and secondary palates and cleft width.
   c. Disruption of the levator veli palatini muscles.
   d. a and b.
   e. a, b and c.

4. There are two groups of muscles essential for effective function of the velar mechanism known as the palatal group and pharyngeal groups. They are made up of the following six muscles:
   a. Levator veli palatini; tensor veli palatini and uvularis.
   b. Palatoglossus; palato-uvularis and inferior pharyngeal constrictor.
   c. Palatoglossus; palatopharyngeus and superior pharyngeal constrictor.
   d. a and b.
   e. a and c.

5. Complications following surgery for velopharyngeal dysfunction may include:
   a. Post-operative infection.
   b. Obstructive sleep apnea and tearing of sutures.
   c. Velopharyngeal incompetence.
   d. a and c.
   e. a, b, and c.

6. The authors mention the following information regarding post-operative outcomes for velopharyngeal dysfunction:
   a. Success rates of between 72% and 97%.
   b. Between 3.1% and 7% of cases experience dehiscence.
c. 10% of cases may need further surgery to repair residual hypernasality.
d. a and b.
e. a and c.

7. Optimal care of the child with cleft palate requires the input of a multi-disciplinary team. A child with cleft palate needs management shortly after birth in order to manage:
   a. Feeding and potential for respiratory compromise.
   b. Surgical repair of the cleft palate.
   c. Nasopharyngeal reflux.
   d. a and c.
   e. a, b and c.

8. The following techniques are used to manage feeding:
   a. Supine feeding, speciality bottles and teats.
   b. Regular burping, speciality bottles and teats.
   c. Upright feeding.
   d. a and b.
   e. b and c.

9. In order to stabilise the airway in infants with Pierre Robin Syndrome, positioning the child on their stomachs is usually enough to avoid airway obstruction.
   a. True.
   b. False.

10. Multi-disciplinary management of a child with cleft palate includes management of conditions commonly associated with cleft palate. These conditions may include:
    a. Eustachian tube dysfunction and otitis media with effusion.
    b. Regular dental care and orthodontic management.
    c. Audiological management of conductive hearing loss.
    d. a and b.
    e. a, b and c.

11. The authors state that the only ‘cleft palate repair that should be considered successful is that which’:
    a. Establishes normal velopharyngeal function.
    b. Restores normal palatal anatomical structure and normal palatal function for speech.
    c. Separates the nasal cavity from the oral cavity.
    d. a and b.
    e. a, b and c.
12. Embryological palatogenesis begins in the fifth week of gestation and is complete by the twelfth week of gestation.
   a. True.
   b. False.

13. Two major factors must be considered with regard to the timing of palatoplasty:
   a. Early development of speech and growth of the upper jaw.
   b. Ability of the child to feed effectively and the risk of aspiration.
   c. The severity of the cleft palate and velopharyngeal dysfunction.
   d. a and b
   e. a, b and c.

14. It is widely accepted that palatal repair should be complete by the age of 2 years.
   a. True.
   b. False.

15. Surgical techniques for repairing cleft palates have been described for hundreds of years. Some of those used today include:
   a. Von Langenbeck Procedure
   b. V-Y Pushback
   c. Furlow Z-Plasty
   d. a and b
   e. a, b and c.

16. Velopharyngeal Dysfunction has many underlying causes, such as:
   a. Velopharyngeal dysfunction in association with Cleft Palate, pre and post operatively.
   b. Syndromic causes and acquired neurogenic disorders.
   c. Post adenoidectomy.
   d. a and b
   e. a, b and c.

17. An evaluation of a persons’ functional velopharyngeal closure is required in order to determine if surgery is required to correct velopharyngeal dysfunction. Evaluations may be conducted using:
   a. Magnetic Resonance Imaging and Videofluoroscopy.
   b. Nasopharyngoscopy and Videofluoroscopy
   c. Nasopharyngoscopy and Gastroscopy
   d. a and b
   e. a, b and c.
18. Velopharyngeal dysfunction may be treated either surgically or prosthetically depending on each client’s needs.
   a. True.
   b. False.

19. Nasopharyngoscopy is a necessary but invasive evaluation of the functioning of the velopharyngeal port. Advantages of this procedure include:
   a. Ease of performance, in rooms by a surgeon or speech language pathologist.
   b. Real-time evaluation of velopharyngeal function during speech.
   c. Assessment of all patients is possible.
   d. a and b
   e. a, b and c.

20. During the seventh week of gestation, the lateral processes of the palate begin to fuse in the mid-line. This process is:
   a. Anterior to posterior in sequence.
   b. Posterior to anterior in sequence.
   c. Is completed by the end of the twelfth week of gestation.
   d. a and c.
   e. b and c.