

# Bifid Uvula, Submucous Cleft, and Speech Regression Post Adenoidectomy

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### Question

**When my 2 yr old had her adenoids and 2nd set of tubes done last July it was discovered that she has a "bifid uvula consistent with a submucous cleft palate." Her speech regressed extensively after the surgery but I was told to "wait and see".**

### Answer

Yes, a bifid uvula is often missed in a birth physical exam as well as later on. Pediatricians and ENT physicians are, or should be, trained to evaluate for bifid uvula and they also should know about the risk of developing hypernasality from adenoid removal. Where adenoidectomy results in hypernasality, a "wait and see" admonition is most often, not an effective resolution for the problem. Yes, I have seen many instances where speech regresses after total adenoid removal.

Having said this, some additional information should be offered: (please bear with me and forgive the technical nature of the comments - I will get back to your situation at the end of the comments)

1. The incidence of bifid uvula in the general population has been established as 1 in 76 individuals (Meskin, Gorlin and Isaacson, July, 1964, The Cleft Palate Journal ). So it is possible to have a bifid uvula without an accompanying submucous cleft palate.
2. A bifid uvula is considered to be a cleft uvula and a microform of cleft palate. When seen with a submucous cleft palate, this finding should signal a risk for total adenoidectomy until the examiner proves this not to be the case.
3. It is also possible, but not common, to have a submucous cleft without a bifid uvula. A submucous cleft involves a lack of either bony or muscle union across the hard and/or soft palate, but with connective tissue continuity across the palates. The result of a submucous cleft, typically, is a soft palate (velum) that has a reduced effective length during function. Where the adenoid is present, it provides a target for contacts of the velum during speech.
4. In instances where there is a bifid uvula and submucous cleft and where an adenoidectomy is recommended for problems of tissue encroachment over the eustachian tube openings, with resultant middle ear fluid, a partial (lateral/peritubal) adenoidectomy can be performed. This procedure leaves a midline mass of adenoid tissue for participation as a target for velopharyngeal closure (closing the nasopharyngeal space).
5. The tonsils and adenoids have a growth cycle. They reach their peak of growth around age 12, then undergo a process of involution or atrophy so that by around age 20, the adenoid should be sparse or absent. The exception to this is the patient with a history of tonsillitis or adenitis (Mason and Warren, November, 1980, JSHD).
6. Over time, patients with submucous clefts who have not undergone adenoid removal, can develop hypernasality as the natural process of involution (atrophy) of the adenoid mass occurs. Where this does not occur over time, the palate has adapted to the gradual change in the architecture of the pharynx. By contrast, a dramatic change in the diameter of the pharynx with adenoidectomy does not permit the shorter submucous cleft palate to adapt.

You mentioned in your question dialogue that your daughter was to be seen by the UNC Craniofacial team. This team is an excellent resource to advise you as to whether your child will in fact outgrow this problem or whether she will require a surgical procedure to correct the hypernasality. Good luck.

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