Mulliken’s Bilateral Cleft Lip Repair: Early Outcome Analysis

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ABSTRACT

Objective: To determine the early surgical outcome of Mulliken’s repair technique for bilateral cleft lip.

Study Design: Descriptive cross-sectional study.

Place and Duration of the study: Burns and Plastic Surgery Centre, Hayatabad Medical Complex, Peshawar, Pakistan, from January 2020 to December 2021.

Methodology: This study included 51 patients with bilateral cleft lip deformity. Patients were evaluated preoperatively to exclude any associated congenital anomalies or comorbidities. Then the patients were classified into mild, moderate, severe, and asymmetrical cases. Outcomes were determined immediately and one week postoperatively, as good (score 16-20), fair (score 11-15), and bad (0-10) on the basis of anthropometric measurements on outcome evaluation criteria (OEC).

Results: Preoperatively mild, moderate, and severe bilateral cleft lips were observed in 18 (35.3%), 6 (11.85%), and 15 (29.4%), respectively, while 10 (19.6%) were bilateral asymmetrical cleft lips. The postoperative outcome score ranged from 16 to 20 (mean 19.2 ± 1.03) which falls in the good outcome range. Nasal symmetry was good in 64.7% (n=33) cases while 31.4% (n=16) patients had satisfactory scores.

Conclusion: Although Mulliken’s repair is by far the most prevalent type of repair for bilateral cleft lip patients, the results can vary markedly. The early outcome evaluation criteria is an objective tool to measure the outcomes.

Key Words: Cleft lip, Bilateral cleft lip, Mulliken, Mulliken’s repair, Day care surgery, Outcome.

INTRODUCTION

There is a paradigm shift to single-stage nasolabial repair and preoperative nasoalveolar moulding. This has made it possible to change the historical dissatisfactory impression about the postoperative surgical outcome of bilateral cleft lip and nasal deformity.¹ The intrinsic and iatrogenic stigmata of bilateral cleft nasolabial deformity can be avoided by preoperative nasolabial moulding and adherence to the surgical principles of achieving symmetry, primary muscular continuity, appropriate size and shape of the philtrum, formation of median tubercle from lateral lip elements and repositioning of lower lateral cartilages to recreate the nasal tip and columella.²-⁴ It requires dedication and craftsmanship on the part of the operator to meet the standards.
Ethical Board (14/REB/B&PSC/19) before the initiation of the study. Patient consent was obtained before including in the study.

Both primary and secondary bilateral cleft lip patients were included irrespective of their gender. Patients with age less than 3 months, syndromic associations and comorbidities were excluded. The sample size was 51.7 Patients were thoroughly assessed by history and clinical examination by the primary surgeons (two) and anaesthesiologists (two). Clinical photographs were acquired preoperatively, on table and one week postoperatively to evaluate the early surgical outcome. Using photographs, the preoperative status of patients was categorised on the basis of the severity of the cleft as mild, moderate, and severe deformity. Incomplete cleft lip is classified as mild. Moderate deformity is a complete but not wide cleft with some tissue contact between the lateral and medial lip segments at rest. Severe deformity is a complete and wide cleft (Figure 1A and 1B) while asymmetrical is a combination of different severities on either side (Figure 1C and 1D). Lip repair with primary rhinoplasty was performed under general anaesthesia.8

RESULTS

A total of 51 bilateral cleft lip patients, including 39 (76.5%) primary and 12 (23.5%) secondary cases were operated on with Mulliken’s technique as shown in Figure 1E. The study population comprised of 31 (60.8%) male and 20 (39.2%) female patients with age ranged from three to 300 months (mean=41.4 ± 6.4 months). Preoperatively mild, moderate, and severe bilateral cleft lips were observed in 18 (35.3%), 6 (11.8%), and 15 (29.4%), respectively, while 10 (19.6%) were bilateral asymmetrical cleft lips and 2 (3.9%) had associated craniofacial clefts. The postoperative outcome score ranged from 16 to 20 (mean=19.2 ± 1.03) which all fall in the good outcome range for both primary and secondary cases (Figure 1C and 1D).

The outcomes of the nasal symmetry was good in 64.7% (n=33) cases while 31.4% (n=16) patients had satisfactory scores. In 3.9% (n=2) cases, nasal symmetry outcome was found poor (Table II). The distribution of OEC score is shown in Figure 1F. The stigmata of the oblique nostril for bilateral cleft lip was present in 6 (11.8%) cases while 2 (3.9%) cases had long lip. The relationship of Nasal symmetry with preoperative severity and type of presentation (i.e. primary, secondary) was not found statistically significant with p-values of 0.237 and 0.184, respectively calculated with chi-square test.

Symmetry of free vermilion (Table II) was good in 84.3% (n=43). The free vermilion symmetry was found good in 73.1% (n=19 out of total 26) and 96% (n=24 out of total 25) during 2020 and 2021, respectively with a statistically significant association (p=0.024, calculated by chi-square test with a confidence interval of 95%).

DISCUSSION

Cleft surgery is constantly evolving and there are numerous studies describing new techniques or modifications to the old ones.10,14 In this series, the authors reported the early postoperative outcome of Mulliken’s bilateral nasolabial repair for both primary and secondary cleft deformities. The OEC score can later on also be used to compare newer iterations to the established techniques.
The study population is a modest one similar to those reported by Mulliken as 50 patients in their series. This study population is larger as compared to the 30 reported by Kim et al. Compared to this study population age, Akintububo et al. reported a presentation age of 3 months to 60 years for cleft surgeries in his series of African population. This study population had a similar composition to that reported by Kim et al. on the basis of preoperative severity. Yuzuriha et al. reported the frequency of asymmetrical bilateral cleft lip deformity as 23%, which is similar to 19.6% for this study population. In this series, the postoperative outcome scores were consistent with the postoperative outcomes reported in the literature. Pinto et al. reported favourable results in terms of bilateral cleft lip nasal deformity stigmata removal when simultaneous nasal correction was performed with cleft lip repair. Chang et al. also shared their experience of simultaneous primary rhinoplasty with over correction in bilateral cleft lip patients preceded by preoperative nasoalveolar moulding as equal to non-cleft patients. Adeyemo et al. reported satisfactory postoperative outcome in 95% cases of bilateral cleft lip, repaired with modified Millard’s technique but their assessment criteria is very brief and ignored the bilateral cleft lip stigmata. Another series by Fakih-Gomez et al. described their results as good bilateral cleft lip repair with excellent symmetry for their technique but without proper qualitative and quantitative assessment criteria. Reddy et al. reported a better cosmetic outcome for Afroze repair in comparison to Millard’s repair. A study by Hammoudeh et al. also showed good results with early nasal repair. In all these studies, the postoperative outcome criteria were different from each other which shows the difficulty of establishing a standardised outcome assessment protocol.

In this series, Mulliken’s nasolabial repair technique was equally effective both for primary and secondary cases with good aesthetic outcome results. The drawback of the study is that it only shows the early postoperative result. To assess the longevity and the influence of growth on the aesthetic outcome, long-term postoperative outcomes need to be assessed in further studies.

**CONCLUSION**

Although Mulliken repair is by far the most prevalent type of repair for bilateral cleft lip patients, the results can vary markedly from one surgeon to another. The early outcome evaluation criteria is an objective tool to measure the outcomes. Further work is needed in order to identify the common causes of low OEC scores and give specific tailored surgical strategies in order to improve the outcomes.

**ETHICAL APPROVAL:** Ethical approval was obtained from the Institutional ethical board at Burns and Plastic Surgery Centre (14/REB/B&PSC/19) before the initiation of the study.

**PATIENTS’ CONSENT:** Informed consent was obtained from the patients for publishing the concerned data.

**COMPETING INTEREST:** The authors declared no competing interest.

**AUTHORS’ CONTRIBUTION:**

- **MK:** Concept, data collection, write-up, data analysis, and interpretation.
- **HU:** Data collection, technical guidance, and interpretation.
- **AK:** Data collection, write-up, and visual design.
- **WH:** Write-up, data interpretation, and proofreading.

All the authors have approved the final version of the manuscript to be published.

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**Table I: Outcome evaluation criteria for bilateral cleft lip repair.**

<table>
<thead>
<tr>
<th>Symmetry</th>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symmetry of the cupid’s bow</td>
<td>0 (0%)</td>
<td>1 (100%)</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Symmetry of the nose</td>
<td>0 (0%)</td>
<td>1 (100%)</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Symmetry of the free vermilion</td>
<td>0 (0%)</td>
<td>1 (100%)</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Vertical symmetry of the lateral lip</td>
<td>0 (0%)</td>
<td>1 (100%)</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Horizontal symmetry of the lateral lip</td>
<td>0 (0%)</td>
<td>1 (100%)</td>
<td>2 (100%)</td>
</tr>
</tbody>
</table>

**Table II: Postoperative outcome of symmetry parameters.**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Unsatisfied</th>
<th>Satisfied</th>
<th>Good</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symmetry of Cupid’s Bow</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>51 (100%)</td>
<td>51 (100%)</td>
</tr>
<tr>
<td>Symmetry of Nose</td>
<td>2 (3.9%)</td>
<td>16 (31.4%)</td>
<td>33 (64.7%)</td>
<td>51 (100%)</td>
</tr>
<tr>
<td>Symmetry of Free Vermillion</td>
<td>0 (0%)</td>
<td>8 (15.7%)</td>
<td>43 (84.3%)</td>
<td>51 (100%)</td>
</tr>
<tr>
<td>Symmetry of Vertical Lateral Lip</td>
<td>0 (0%)</td>
<td>2 (3.9%)</td>
<td>49 (96.1%)</td>
<td>51 (100%)</td>
</tr>
<tr>
<td>Symmetry of Horizontal Lateral Lip</td>
<td>0 (0%)</td>
<td>3 (5.9%)</td>
<td>48 (94.1%)</td>
<td>51 (100%)</td>
</tr>
</tbody>
</table>

Outcome Score: Good 16-20; Fair 11-15; Bad 0-10.
REFERENCES


