

Feeding Cleft Palate Babies—Today's Babies, Today's Methods

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There is one certainty that all of us must concede in our mutual concern for the cleft palate child. Before the plastic surgeon can perform his first operation, before the orthodontist can prescribe the first corrective measures, before growth and development progresses to a time of concern for speech production, before everything else, this baby must survive. Unless he reaches a state of adequate nutrition, the outlook for successful management by any speciality is diminished. Caloric, fluid, and chemical balance is best realized through the baby's regular oral intake of a normal diet.

Many will remember the earlier management of the cleft babies. All mothers usually were kept in the hospital a week or more. These infants remained long after their mothers went home. We thought that only medical "experts" could provide needed care and had little concern for the separation of the baby from his parents. Frequently, our medical centers received these newborns. They arrived by ambulance or "mercy flight—" feeding tubes taped to their faces—not infrequently tracheostomies already performed. Incubators, oxygen tanks, and suction machines completed the picture of dire medical emergency.

In every conceivable way, we seemed to point to the differences from so called "normal" newborns. We panicked the parents with procedures and equipment. Little wonder they were reluctant to take the little one home to his place within the family.

Now, let's look at some of the changes that have come about. Medical and hospital costs have soared. Resistant infections may jeopardize the lives of infants grouped in nurseries. And, we've had second thoughts about separating babies from their mothers.

Today, the newly delivered mother goes home from the hospital on her second or third post-partem day. And the cleft palate baby, ready or not, usually goes home with his mother. There is no longer the hope that he will have regained his birth weight and be thriving. In fact, often this infant with a potentially serious feeding problem, is sent home quickly and mother, rather than an overburdened nursing staff, must cope with the problems.

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The obstacles to optimal care and feeding of this infant may be varied. The oral defect itself may represent an area of real difficulty. Often, the emotional response of the family may present an equally serious handicap.

We cannot deny the immediate emotional impact on the families of these children. We live in an era of the "hollywood image"—a time for beautiful, successful people. These parents have not received the lovely, unblemished child that they had expected.

Added to this realization, there are new financial worries, confusion of information, disturbing thoughts of guilt or blame, and the tired new mother who now has even more than the usual letdown or depression. Whatever else can be deferred in the "worrying department," she cannot delay for long the immediate need to feed a hungry newborn. Nor does it reassure the parents to find that in many instances their doctor or the nurses in the community have had little or no experience in the management of such defects.

Frequently, when ready to leave the hospital, the parents are given equipment which they are advised to use for feeding. Maybe just a name or description of the equipment sends a frantic father and grandparents scurrying around to find what they think is essential to the newcomer's welfare. If they are fortunate enough to locate the mysterious item, they often find it quite expensive, frequently in short supply, and there are no directions. So the family are made more aware of their baby's differences as they begin the struggle to develop a feeding routine.

What should be a pleasant, relaxing enjoyable time for both baby and mother often becomes the source of great anxiety, failure and defeat.

In our metropolitan areas, there are medical specialists who are able and happy to counsel and comfort these families. On the other hand, where the population is rural (in Oregon, we cover almost 100,000 square miles) we frequently find a lack of experience with such defects.

A new specialized nursing service to assist these families is offered as a part of the Crippled Children's Division program at the University of Oregon Medical School. A pediatric nurse can provide immediate, practical assistance in the early care and feeding of babies with oral clefts. Babies and parents referred, may be visited in the newborn nursery, as well as after their return home. Instruction with encouragement in feeding and other aspects of early care is provided.

The pediatric nurse by her professional training and experience, has a distinct advantage in this area. She can counsel and guide the family toward a satisfactory feeding program. The particulars of safe complete care and attention to details are stressed. The family must realize that the eventual cosmetic and functional outcome for their child depends upon this attention, both before and after the surgical repair.

The baby must receive an adequate diet, he must retain it, and both the

baby and his mother should be satisfied by the outcome. Realistically, the baby's differences are acknowledged, but not emphasized.

We have found that those skills for giving good care can be acquired quickly and well by most parents. They are grateful to have professional guidance and management.

Cleft Palate Feeding Technique

We are familiar with many different devices used for feeding babies with problems associated with their clefts. We have used in-dwelling gastric tubes, repeated gavage feedings, and specially designed syringes and nipples. Frequently equipment designed for some other purpose is used. Often the use of such unusual equipment tends to emphasize the infant's differences and does little to advance parental acceptance of this baby. Furthermore, many of the items are not readily available, and they may be quite costly. The use of much of this equipment preceded the development of today's more adaptable materials.

We believe that the feeding procedure and equipment needed for these infants is basically the same as that for other babies. These babies can be successfully fed, using a plastic nursing bottle and a pre-softened "premie" nipple. The nipple is attached to the bottle by a circular collar which allows for some head movement and also eliminates vacuum formation in the bottle. The plastic bottle can be squeezed gently to assist the baby, decreasing his effort and lessening the time needed for feeding.

There are some problems when parents have been instructed simply to "use big holes in the nipple." How big? How many? How do you make them? We find that a cross-cut nipple, whether premie or regular, works best. Rather than cut holes that allow the milk to pour out, the cross-cut is closed until the baby with minimal pressure opens it as he chews and swallows, establishing a nursing rhythm.

Having the entire feeding in one container permits a continuous process. Without interruption, there is less crying and air feeding. The "stop and start" technique of filling syringes, droppers, and spoons is eliminated.

Mother can now manage the feeding without extra hands. She can hold the baby in a normal semi-sitting position, rocking and cuddling him as she has her other babies. The equipment doesn't accent his differences. Most important—It Works!

The routine nature of this technique should encourage other family members and sitters to substitute for mother occasionally, and this too is important. Furthermore, the bottle and nipple are readily available, reasonable in cost, easy to clean and sterilize. Soft nipples, left over from older siblings, can be used. Mothers usually change from glass to plastic bottles any way, when the baby gets older and more active. We also find that spoon feeding solid baby foods is quite successful, especially when introduced early.

Although we are considering primarily the feeding of the child with

cleft palate, we must remember that those with *cleft lips only* also present complaints relative to the difficulty of feeding. Whether the problems are real or imagined, the families are given the same opportunities for help. Our experience has been that these babies seldom have serious mechanical problems, but the emotional support is certainly indicated. While breast feeding can be successful in babies with clefts of the lip only, it is not reasonable where a palatal defect prevents efficient nursing.

Conclusion

In cleft palate as in every other chronic health problem, our goal is to bring the individual as near as possible to an appearance of *normalcy*. This means cosmetically, functionally, and in his social adjustments and personality. We believe that a good foundation for this total process lies in this basic approach to feeding the baby.

This is our challenge . . . Feed today's babies by today's methods . . . that they may live better tomorrow.