

Animal Dental Center

2409 Omro Road

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November 2005

Palate Defects and Their Management

Palate defects are not frequently seen in veterinary practice, but when they are present, these conditions can vary in severity from a chronic source of rhinitis to a life-threatening problem. Palate defects can be either acquired or congenital. Foreign bodies, maxillofacial trauma from auto accidents, gunshot wounds, periodontal disease and electric cord burns can cause acquired defects.

Congenital defects develop due to the lack of complete connection of the palatine shelves during fetal maturation. The result may be a primary palate defect, secondary palate defect, or a combination of both. Primary palate defects occur when the incisive bone does not develop completely. These are described as a "cleft lip" or "hare lip". Primary defects can be mild and represent a cosmetic defect or may interfere with a complete seal when newborn puppies are suckling and create a life-threatening scenario. Secondary defects are due to the lack of closure of the hard or soft palate, or combination of both. Again, these palate problems can cause significant problems with nursing puppies and predispose them to aspiration pneumonia. Early detection and nursing care such as tube feeding is essential to success. Tube feeding is recommended until the puppy is large enough to receive alternative feeding means that by-pass the oral cavity such as esophagostomy or gastrostomy tube. This may not be practical in small breed puppies and long-term tube feeding may be necessary to mature these puppies to an age that is more conducive to anesthesia and surgical correction of the defect. Ideally, these puppies should be 12-16 weeks old to undergo anesthesia and surgical repair.

Acquired defects usually are the result of some type of trauma and create an opening from the oral cavity to the nasal cavity. The communication allows food, saliva, and oral bacteria to enter the nasal cavity creating a source of chronic upper respiratory infection. In more severe cases, aspiration pneumonia is a legitimate concern.



Providing T.L.C through dental & oral surgical care

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Depending on the defect size and location, various palatal mucosal transposition flaps can be utilized to close the opening into the nasal cavity. Tenets of oral surgery apply with creation of flaps larger than defects, gentle tissue handling, maintenance of blood supply to flaps, suturing of fresh cut mucosal edges to fresh cut mucosal edges, lack of tension across flaps, and placement of suture lines over connective tissue whenever possible. It is important to remember multiple surgeries may be necessary to completely close some defects. Following surgical repair of either congenital or acquired defects, esophagostomy, pharyngostomy, or gastrostomy tubes allow for feeding while preventing stress over the repair and contamination from food particles. Defects should be evaluated at 2, 4, and 6 weeks following repair, allowing soft diet and water per os after the 4 week recheck. Further follow-up at 3 and 6 months is suggested.



During procedure

Sincerely,

Dale Kressin D.V.M

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Technician Tips

1. **Mouth gag risks!** Be careful when using mouth gags. Spring loaded mouth gags can stress the anesthetized patients TMJ (temporomandibular joint). This can be very painful when they wake up.
2. **Mouth gag substitute!** Syringe needle caps may be an alternate (less force) to spring loaded mouth gags.



Repaired Palate



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