as part of multidisciplinary teams. Maxillofacial surgeons and ear, nose, and throat surgeons and paediatric surgeons also perform this surgery in other centres. What is important is not the surgical specialty but technical ability and the desire to improve the management of the deformity. Attempts are being made to establish multicentre studies. The need for surgery in patients with cleft lip and palate is rarely disputed, nor is the need to minimise the number of variables to produce meaningful data on the outcome of a specific procedure rather than on whether it has been used appropriately.

Speech therapy for patients is particularly specialised. While at local level there are insufficient patients to justify a specialist, one solution is for a specialist to liaise with local therapists to assess needs and treatment. Providing part of the process at a large sometimes remote, centralised unit does not cause difficulties in other areas: this is exemplified by the work of the Nottingham Paediatric Cochlear Implant Group, which provides a national service with few problems related to distance because of effective communication among all involved.

Excellent results require excellent primary surgery, but, unlike the authors of the editorial, most contemporary British cleft surgeons believe that it is vital that they should attempt to learn from more than one centre of excellence and on a worldwide scale. Functional surgery has theoretical appeal, which has yet to be substantiated in practice. Though it is of potential benefit, it cannot be lauded as the complete solution to the management of cleft lip and palate, as the authors claim.¹⁻³ Definitive solutions are elusive, but we believe that the future of cleft surgery lies with specialist multidisciplinary teams providing a complete service to patients and their families with simultaneous participation in multicentre studies. This should be undertaken in an open minded manner without the suggestion that any one surgical specialty has an absolute right to any particular anatomical site or surgical procedure.

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- 1 Markus T, Ward Booth P. Managing cleft lip and palate. *BMJ* 1995;311:765-6. (23 September.)
- 2 Shaw WC, Dahl E, Asher-McDade C, Brattstrom V, McWilliam J, Mars M, et al. Eurocleft. A six centre international study of treatment outcome in patients with cleft lip and palate. *Cleft Palate Craniofac J* 1992;29:413-8.
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Language outcomes are important

EDITOR,—Tony Markus and Peter Ward Booth report that the outcome of cleft lip and palate surgery in Britain is poor compared with that in other European countries.¹ It is regrettable that they refer only to the outcome measure of facial growth and make no reference to speech, which is recognised as an equally important indicator of the success of surgery.² Furthermore, when they mention speech and language therapy it is to recommend treatment in local district general hospitals, where, they say, speech and language therapy services are "well placed and funded to provide a comprehensive service." This is a misinformed generalisation. Many district general hospitals do not have clinicians specialising in cleft palate. In advocating the dispersal of speech and language therapy services to generalist clinicians Markus and Ward Booth apparently fail to appreciate the

specialist nature of such therapy for patients with cleft palate. A similar implication is made in their recommendation for surgery to be undertaken by high volume but "non-cleft specialist" operators.

In regional cleft palate centres, specialist speech and language therapists are consultant members of the multidisciplinary team, assessing, diagnosing, and jointly planning management. They are experienced in the use of endoscopy, videofluoroscopy, and other specialised techniques, which are often not available in district general hospitals. They act as advisers to speech and language therapists in the community and are involved in higher education and research.

Continued improvement in the service to patients with cleft palate requires clinical skill and reliable research and audit data. Many surgical and orthodontic colleagues understand that speech problems related to cleft lip and palate are complex and therefore would not advocate the transfer of care exclusively to generalist speech and language therapists. If it is our aim to excel in Britain then it is contradictory to undervalue specialists.

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An invitation for Markus to present his results

EDITOR,—The Craniofacial Society of Great Britain is a multidisciplinary society for the study of cleft lip and palate and other craniofacial anomalies. It exists to promote advances, especially in interdisciplinary research and treatment, and ultimately to enhance the quality of care of affected patients. Central to this research is the objective evaluation of the results of treatment regimens with a view to improving current practices. Such research must be the object of external peer review. Where there are genuine differences of opinion over treatment regimens, care needs to be taken to avoid causing confusion to patients and their relatives.

To this end I was interested to read Tony Markus and Peter Ward Booth's editorial on managing cleft lip and palate,¹ and an article in a newspaper concerning the work of Markus and his colleagues.² I therefore extend an open invitation to Markus and his colleagues to present their results in a consecutive series of patients, externally verified, to peers at the next annual scientific conference of the Craniofacial Society of Great Britain, to be held at Royal Holloway College, Egham, on 24-26 April next year. This invitation is made in the spirit of promoting constructive dialogue between colleagues and objective evaluation of new treatments and discoveries for the long term benefits of patients.

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- 1 Markus T, Ward Booth P. Managing cleft lip and palate. *BMJ* 1995;311:765-6. (23 September.)
- 2 Le Fanu J. The anatomy of the face; body and mind. *Times* 1995 May 4.

Authors' reply

EDITOR,—While it is encouraging that our editorial generated interest, it is surprising that this response should occur now. The editorial was based on papers published up to four years ago, which when published generated no correspondence. Clearly, a response to the original papers would have allowed the authors to comment and would have encouraged debate in a specialist journal.

It remains worrying that M J Timmons, R W Pigott, and Augustin Cabre and colleagues fail wholeheartedly to accept the accumulating evidence which suggests that we must try harder to improve the outcome of cleft surgery in Britain. There also seems to be a continued reluctance (though not on the part of Cabre and colleagues) to acknowledge the importance of anatomical specialisation despite this being the norm in other surgical disciplines and a prerequisite to the establishment of cancer centres. Timmons, Pigott, and Anne Harding and Kim Harland criticise the study as not evaluating every aspect of outcomes of cleft surgery. While in principle we support their view, it is important to recall studies, which showed that in the past most cleft surgeons kept no records at all.¹

We are encouraged that Pigott has radically altered his technique at least three times to seek improvements; the last technique used is not dissimilar to ours.² We share his view that dental training is a valuable part of the training of a cleft surgeon. Pigott will no doubt be pleased to note the good results of evaluation of nasal form with the Delaire technique reported by maxillofacial surgeons with a dental and medical training.³ There are, of course, other papers by maxillofacial surgeons that look at other aspects besides facial growth.⁴

Timmons's letter is confusing since none of the papers quoted audited primary cleft surgery.

We agree with Harding and Harland, who emphasise the need for specialist speech and language therapists. Such therapists are available in increasing numbers in larger district hospitals, where they can study outcomes and carry out research—features not obviously forthcoming from some of the large regional centres.

Finally, we wish to comment on the letter from the Craniofacial Society, which shares our enthusiasm for publishing our views and results in peer reviewed journals. We are sure, however, that the society will not be surprised that we wish to present and publish our findings at our own meetings and in our journal. The meetings and journal of the British Association of Oral and Maxillofacial Surgeons are always well supported by all specialties from Britain and abroad, including many members of the Craniofacial Society. It is undesirable to present the same material at different meetings and certainly wrong to publish in two journals. Naturally, as new data become available we would consider reporting them to the society, but it is just one of many such groups.

There is no doubt that cleft surgery is undergoing a most rigorous appraisal, which is as overdue as it is desirable. If our editorial, or the involvement of British oral and maxillofacial surgeons in primary cleft surgery, in some way helps this process we will be delighted. Accepting the status quo is, however, not good enough for our patients.

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