Review of: "Primary Surgical Treatment of Cleft Palates in the Algerian Hospital Environment"

Rafael Denadai

Potential competing interests: The author(s) declared that no potential competing interests exist.

The authors should be congratulated for their study. This is a very interesting study that deserves comments aimed at transmitting additional information to readers who could apply such information in their practice.

For exclusion criteria, how about the presence of Pierre Robin sequence?

For definition of oronasal fistula, please adopt the following: “any communication between the oral and nasal cavities due to complete, full-thickness repair breakdown”. You may, for example, use these references to support this definition (Cleft Palate Craniofac J. 2022 Sep 6:10556656221123917. Cleft Palate Craniofac J. 2021 Dec 3:10556656211064769. Plast Reconstr Surg. 2022 Jan 1;149(1):197-201.)

Please, provide further details of the diagnosed oronasal fistula using, for example, the Pittsburgh Fistula Classification System.

How about the gingival area (using the Pittsburgh Fistula Classification System: type VI, lingual alveolar; and type VII, labial alveolar.)? Is it managed during primary lip or palate surgeries?

Please, provide the regular protocol for primary cleft lip repair (timing and technique) and primary cleft palate repair (timing).

It is not clear how the different cleft palate repair techniques were used across the cohort. Is there a protocol to select each type of procedure?

Is Veau – Wardill - Kilner technique adopted for Veau III and Veau IV cleft palates?

For speech therapy, how about the age to start regular follow up and screening for velopharyngeal insufficiency? How to manage different patients like patients who were operated before 12 months of age versus patients who were operated after 36 (or older) months of age?

“About 15% of our patients presented a scar veil appearance, 65% a soft veil (normal) aspect, and 10% a sclerotic veil. In addition, 20% of the patients exhibited a short veil, and 10% of them exhibited a pathologically-looking uvula that is either bifid or hypoplastic.” Is it possible to provide a reference to support such evaluation method?

“veil” is not a regular nomenclature. I would suggest to adjust it across the study.

“It should also be noted that 61.6% of these surgical operations concerned the cleft palates and 38.4% the velar clefts”. Is it related to Veau I and II versus Veau III and IV?

“Among the cases studied, 12 of them presented palatal fistulas that were closed by surgery.” I would suggest to add % of fistula. 12 of 85 surgeries?

“The speech therapy examination, based on Borel – Maisonny’s classification (Figure 7), it allowed finding that approximately 46% of patients who underwent *surgery* by the Wardill technique had a phonation that is classified II / 2 IIB, and approximately 53% of them presented a phonation classified IIM and III. However, 82% of the patients operated on by Sommerlad intravelar veloplasty (IVV) and Furlow Z-plasty techniques possessed a phonation classified II / 2 IIB, while 2% of them had a phonation classified IIM and III, as summarized in Table 1.” I would suggest to apply a statistical testing here to define if you have (or not) significant difference between the type of surgeries.

For figure 1, Veau classification is classically for Veau Types I to IV, not including Veau II (different types) or submucous cleft palate. I would suggest to adjust it…

For figures 1, 2 and 3, etc, I would suggest to use English language.

For figure 5, I would suggest to address similarities and differences when your approach is compared with the original Furlow method. For example, note that the angle of Z-plasty is different.

For fistula repair, when it is indicated? After diagnosis? Presence of symptoms? I would suggest to address it.