DEPENDING ON GENDER, MORPHOMETRIC CHARACTERISTICS OF THE FACIAL REGION OF THE CHILDREN WITH CONGENITAL CLEFT LIP AND PALATE.

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ABSTRACT

The purpose of the study is to determine the anthropometric parameters of the face in children with congenital cleft lip and palate. The study showed that the morphological and physiognomic height of the face in children with congenital cleft lip and palate is less than in healthy children.

The development and growth of the maxillary complex in children with CCLP is a widely discussed topic in any surgical procedure. The studied changes in the parameters of the craniofascial region lead to a decrease in maxillofacial pathologies, as well as growth and development of the definition, which contributes to the non-hormonal development of the child. The introduction of the obtained data into practical healthcare will reduce the proportion of maxillofacial anomalies

Key words: monitoring, morphometry, cleft, child, lip, palate.

INTRODUCTION

Assessment of the state of physical development is impossible without data on anthropometric indicators of various age groups.

Indicators of physical development are anthropometric data, the rate of their change in the process of growth, the harmony of development, the ratio of calendar and biological age, constitutional features. The presence of congenital cleft palate puts the child in unfavorable conditions for his physical development. The more extensive the defect, the more violations the child's body undergoes during its development. The limits of fluctuations of anthropometric parameters of parts of the human body and the dentoalveolar system are influenced by many interdependent factors.

A family history can be found in about 40% of cases, although the actual genetic factors behind cleft lip and palate are extremely complex. A commonly cited statistic states that the risk of unaffected parents having a second child with the anomaly is approximately 1 in 20. The etiology of cleft anomalies is multifactorial. Some environmental factors, such as phenytoin taken during pregnancy, increase the risk of cleft lip and palate, and other medications (such as retinoids), folic acid deficiency, and fetal alcohol syndrome also increase the incidence. Folic acid supplementation has been shown to reduce the incidence.

In the Republic of Uzbekistan today, the birth rate of children with congenital cleft lip and palate is higher than the national average. Violations of such vital functions as breathing, nutrition and speech, aesthetic defects associated with congenital cleft lip and palate, adversely affect the overall physical and intellectual development of the child. The feeling of inferiority, the reaction of others to speech cause such a child severe experiences, which, of course, is reflected in the formation of his psyche. These psychological layers, in turn, further exacerbate speech disorders. Speech defects not eliminated in childhood subsequently hinder the choice of profession; interfere with work and everyday life.

Based on the above, we have set the following **goal**: Will study the morphometric parameters of the craniofacial region in children of the 1st period of childhood with congenital cleft lip and palate and its correspondence to the principle of the golden section, including various pathological conditions.

Material and research methods.

630 children of the I and II periods of childhood with CCLP at the age of 3 to 12 years were examined. Among them 390 (61.9%) boys, 240 (38.1%) girls.

When determining the shape of the skull of children with CCLP, depending on gender in the total number of boys and girls, it also had differences. The longitudinal diameter of the skull in girls is larger (16.09 cm) than in boys (15.64 cm), the transverse size of the skull, head girth, transverse size of the forehead, height and vertical diameter of the skull were similar.

When the parameters of the size of the base of the skull were determined, in both sexes it was revealed that the length of the base of the skull and the width of the base of the skull were also greater in girls (18.11cm and 15.61cm) compared to boys (15.67cm and 13.63cm).

The facial area, namely the zygomatic diameter in boys was significantly larger (9.8 cm) than in girls (9.4), as was the mandibular diameter in boys (8.8 cm). But the morphological face height of the boys was lower by 0.2 mm (boys - 9.6 cm, girls - 9.4 cm). The physiological height of the face, the height of the nose, the width of the nose, the external orbital width, the interorbital width, the height of the mucous part of both lips and the width of the mouth in both sexes, the measurement indicators coincide

The chest area, when measuring children with CCLP of both sexes, was distributed according to the following parameters: body length (1. standing height, 2. sitting height), body weight, body length, chest circumference (1. in a pause, 2. at the height of inspiration), with full expiration, abdominal circumference, length of the upper segment, transverse chest diameter, anterior-posterior chest diameter and chest height. The boys were a little short (124cm) and the girls were taller (126cm). In all other respects, this is body weight, torso length, chest circumference (1. in a pause, 2. at the height of inspiration), with full exhalation, abdominal circumference, length of the upper segment, transverse chest diameter, anterior-posterior chest diameter and chest height did not differ between boys and girls.

When measuring the upper limbs, no special changes were revealed, except for the measurement of the length of the upper limb and shoulder length, a high indicator was in girls (52.5 cm - 23.2 cm), and in boys it was slightly lower (50.4 cm - 22.4 cm).). Shoulder circumference, forearm length and hand length were similar in all groups.

Our study was to determine and identify indicators of the physical development of both sexes of children with CCLP and this was based on the measurement of the lower extremities. The measurement of the lower limb began with measuring the length of the lower limb (a) the point of the upper anterior axis of the ilium and b) the point on the upper edge of the pubic articulation), the length of the femur (a) the lower limb and b) the upper point of the medial tibial condyle) , hip girth, pelvis width, calf length, calf girth. The length of the lower limb in girls was higher (62.3 cm), in boys it was low (59.3 cm). The length of the thigh had a difference of 1 cm, in girls it was 31.6 cm, in boys it was 30.5 cm. 10cm; 29.8cm; 25.2cm and 19.1cm).

The number of teeth in girls with CCLP was 22 and in boys with CCLP 21.

RESULTS AND THEIR DISCUSSION

Analysis of the results of the conducted studies showed that in the main group of I and II childhood periods (group 1 of children - DVRHN) the facial part, namely the morphological height of the face, the physiological height of the face is low compared to the other groups of children with CVRH. This proves the underdevelopment of the middle zone of the face due to the lag of the maxillae in growth due to scars after surgical interventions such as

cheilorhinoplasty and uranoplasty. In addition, the indicators of the width of the nose also differed, and were wider (flattened), this indicates some shortcomings, errors, or difficulties in the formation of the wings of the nose during cheilorhinoplasty in BCCLP. The height of the mucosal part of both lips was also smaller, as was the width of the mouth compared to other groups. This can be explained by the fact that during the formation of the shape of the upper lip during the operation there is a difficulty as a lack of tissue for closing and at the same time the formation of the anatomical shape of the upper lip in children with BCCLP, since the cleft due to the bilateral anomaly is closed with a maximum restoration of the anatomical shape of the lip it is difficult that the natural operative field heals by primary intention forming scars (fibrous tissue).

The corners of the mandible in the main group are sharper 117/115 C, this is explained by the fact that, with underdevelopment of the upper jaw, due to fibrous tissue after cheilorhinoplasty and uranoplasty, the maxillae lags behind in growth, since the fibrous tissue does not have the ability to stretch and the bone tissue which to be under the fibrous tissue does not develop, the mandiblebone, depending on the upper jaw, grows without obstacles, but since there is no contact with the upper jawbone, namely with the teeth, the chin section of the mandible changes direction in growth and rises (protrudes) forming a progenic bite.

Due to the progeny of the mandible, the angles of the mandible in the main group (group 1 of children - DVRGN) become sharp. Differences in the parameters of the parameters of the craniofacial region were observed mainly from the age of 5 in boys and from the age of 6 in girls compared with 3 years of age, along with this, significant differences were clearly observed from the age of 6-7 years.

CONCLUSION

All data were analyzed and primary measurements were obtained. Data obtained in addition to the mean standard deviation analysis showed statistically significant associations and 95% confidence intervals. $P<0.05$ ($P>0.05$) was taken into account. All measurements were retaken 6 weeks after the original measurements to detect errors associated with linear measurements. Repeated measurements analysis revealed no differences between them.

With age, the child undergoes various changes in the dentoalveolar system and bite, which are associated with the nature of nutrition, the change of milk teeth to permanent ones. To achieve the effectiveness of complex treatment of children with cleft lip and palate, it is necessary to study in detail the dynamics of movement of the segments of the maxillae throughout all age periods.

The origin of secondary deformities of the alveolar process of the upper jaw, the determination of the optimal timing and scope of surgical interventions, all this is generally very relevant understanding, it also indicates the need for further more extensive research to solve this problem.

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