INTRODUCTION

Palatoschisis or cleft palate is one of the more commonly described congenital defects in man and domestic animals. In humans, its prevalence ranges from 0.05 to 0.3% of all pregnancies, depending on population, sex and geographical location (Thornton et al., 1996), while in domestic animals, an average of 0.6 cases per 1000 births has been reported (Noden and de Lahunta, 1985). The only non-mammalian species in which the oral and nasal cavities are entirely separated from each other through the palate belong to the family of the crocodilians. In these species, the palate permits breathing while the mouth is submerged under water (Ferguson, 1981), whereas the presence of a correctly developed palate in mammals is essentially to allow the proper swallowing of food and liquids, and to enable the suckling of milk by the newborn (Nelson, 2003).

In an affected individual, alimentary nasal discharge, due to the inability to generate suction and the presence of an open connection between the oral and nasal cavities, is one of the first symptoms to be noticed. Food entering the nasal cavity through the defect also causes irritation and inflammation of the nasal...
mucosa, resulting in sneezing and nasal discharge (Nelson, 2003). Swallowing difficulties, expressed by coughing and regurgitation, eventually lead to severe malnutrition and life-threatening aspiration pneumonia (Ishikawa et al., 1994).

Medical intervention in such cases is therefore indispensable for the survival of the patient and to guarantee a reasonable quality of life (Griffiths and Sullivan, 2001; Nelson, 2003). Whereas in human medicine numerous therapeutic possibilities have been developed to compensate for or correct palatoschisis, pets suffering from a cleft palate are usually euthanized for welfare, financial and/or practical reasons. In the past, surgical correction of a cleft palate in animals has been associated with a high failure rate (Howard et al., 1974). However, newer techniques are improving the success rates in dogs (Ingwersen, 2005).

Still, the decision whether or not to perform surgery should be carefully considered, taking all practical, technical, financial and ethical issues into account. A thorough knowledge of the normal development and conformation of the palate and a broad understanding of the etiology and pathogenesis of the different types of cleft palate are indispensable in this regard. This article is therefore intended to provide a brief review of the developmental anatomy of the palate and the pathomechanisms involved in the schistopalatine syndrome, with special reference to the dog.

EMBRYONIC DEVELOPMENT OF THE PALATE

Morphogenesis of the palate

In the early embryo, the primitive mouth or stomodeum is covered by the frontonasal prominence, flanked by the maxillary processes of the first visceral arches and lined ventrally by the mandibular processes, which fuse with each other to form the lower jaw (Figure 1).

At the rostral end of the frontonasal prominence, just dorsal to the stomodeum, two nasal placodes invaginate to form the nasal pits or nasal sacs. Subsequently, the ventral walls of the expanding nasal sacs fuse with the roof of the stomodeum, after which these so-called oronasal membranes degenerate, hereby creating a single oronasal cavity. The dorsal half of the oronasal cavity is subdivided by a primitive nasal septum, while its ventral half is mainly occupied by the voluminous tongue. The dorsal surface of the tongue is directly apposed to the ventral aspect of the primitive nasal septum, which is therefore often referred to as the primitive palate (Noden and de Lahunta, 1985).

Externally, each nasal pit is circumscribed by two swellings: a lateral and a medial nasal prominence. On either side, the lateral nasal prominence is soon reached by the rostrally expanding maxillary process. Each maxillary process subsequently bridges the nostril ventrally and finally fuses with the ipsilateral medial nasal prominence. Both medial nasal prominences expand markedly and eventually contact each other in the rostral midline (McGeady et al., 2006).

The development and fusion of all these components is essential for the correct formation of the nose, upper lips and upper jaws. After the medial nasal prominences have fused with each other, they form the median palatine process, which extends caudally as a shelf-like projection into the oronasal cavity. This structure, along with the rostroventral part of the nasal septum, creates a clear separation between the stomodeum and the two nasal cavities in the rostralmost part of the oronasal cavity and is therefore referred to as the primary palate. It persists as a small, triangular structure that corresponds to the rostralmost part of the definitive palate, in which the incisive bones develop (Noden and de Lahunta, 1985; Sinowatz, 1991).

The development of the secondary or actual palate starts with the development of the lateral palatine
processes, often referred to as the palatal shelves, emerging from the medial aspects of the maxillary processes (Figure 2). Both lateral palatine processes initially grow in a ventromedial direction, thereby occupying the space between the lateral surface of the tongue and the mandibular processes. At a specific time, the palatal shelves elevate to a horizontal position dorsal to the tongue, so that their free margins become directly apposed. Almost immediately thereafter, both palatal shelves fuse with each other and with the nasal septum, resulting in the definitive separation of the oral cavity from the nasal cavity and the partitioning of the nasal cavity into two separate chambers (Ferguson, 1988; Thornton et al., 1996; Kang and Svo-boda, 2005).

Mechanisms of palatal shelf elevation

The actual process of palatal shelf elevation and fusion takes only a few minutes to a few hours (Dudas et al., 2006) and is controlled by complex regulatory mechanisms. The forces that drive the palatal shelf elevation are primarily intrinsic factors of the composing tissues. A progressive accumulation and hydration of hyaluronic acid induces swelling of the mesenchymal stroma and a decrease in mesenchyme density (Morris-Wiman and Brinkley, 1993). The orientation and direction of the resulting expansion of the palatal shelves is controlled by other components of the extracellular matrix such as collagen type I (Foreman et al., 1991; Mansell et al., 2000), but also by the covering epithelium and its underlying basement membrane (Morris-Wiman and Brinkley, 1993).

Extrinsic factors also play a major role in the re-orientation of the palatal shelves. These consist of active and passive movement of the tongue (e.g. by traction on the genioglossus muscles due to the elongation of the lower jaw) and non-palatal muscular contractions such as opening of the mouth, sudden hyperextension of the neck and swallowing (Brinkley et al., 1978). The final goal of these forces is to depress or retract the tongue so that the space between the two palatal shelves is cleared, allowing the palatine processes to reorient (Fraser, 1967; Chou et al., 2004).

Mechanisms of palatal shelf fusion

The size of the lateral palatine processes is such that as soon as they assume a horizontal position, their margins are apposed (Noden and de Lahunta, 1985). Their medial edges are covered with a bilayered epithelium consisting of a basal cuboidal epithelial layer commonly referred to as the Medial Edge Epithelium (MEE) and an outer peridermal layer composed of flattened cells. During a process called peridermal peeling, the periderm on the edge of the palatal shelves is dissolved through apoptosis or migration of the peridermal cells towards the oral or nasal surface (Bittencourt and Bolognese, 2000; Dudas et al., 2006). The underlying MEE is exposed and acquires the competence to interact with the MEE of the contralateral palatine shelf (Dudas et al., 2006).

Disappearance of the midline epithelial seam

Following adhesion of the lateral palatine processes to each other and to the primitive nasal septum, the epithelium that once covered the apical surfaces of these three processes becomes trapped within the junction site. These cells arrange themselves into the Midline Epithelial Seam (MES), a double wedge-
shaped epithelial cell mass that needs to disappear to allow mesenchymal confluence and completion of the process of palatal fusion (Jin and Ding, 2006). The bases of the two wedges abut on the oral and nasal surfaces of the palate, respectively, while their edges are in contact with one another in the palatal center.

Three different mechanisms are theorized to be responsible for the disintegration of the MES. Cuervo et al. (2002) have shown that apoptosis is over-abundant in the MES and that this programmed cell death is necessary for the normal closure of the palate. On the other hand, Griffith and Hay (1992) experimentally confirmed the observation by Ferguson (1988) that more than 50% of the MES cells undergo epithelial-mesenchymal transdifferentiation and transform into fibroblasts. As a third option, Carette and Ferguson (1992) proposed that the cells of the MES migrate towards the oral and nasal cavities to incorporate themselves into the surface epithelium. Most probably, the disintegration of the MES is directed by a combination of all three mechanisms (Martinez-Alvarez et al., 2000).

TYPES OF PALATOSCHISIS

A congenital palatal fissure is the result of the non-closure either of the primary or of the secondary palate, or of a combination of the two (Warzee et al., 2001). In cases in which the primary palate is involved, the anomaly is always associated with defects of the upper lip (cleft lip, schistocheilia) and upper jaw (gnathoschisis), resulting in severe facial malformation. A fuller description and further classification of this group of defects, however, falls beyond the scope of this paper.

The term palatoschisis or cleft palate is typically reserved for defects of the secondary palate only. Within this group, a further distinction is made between complete clefts, in which both the hard and the soft palate are affected (Figure 3), and incomplete clefts, which usually involve only the soft palate (Sini-baldi, 1979; Thornton et al., 1996).

Typically, the palatal fissure is present in the midline as a more or less large gap connecting the oral and nasal cavities, and exposing the nasal septum in the oral cavity. In cases where only one of the two lateral palatine processes manages to fuse with the primitive nasal septum, a cleft palate will be unilaterally present. Bilateral clefts can also occur at the level of the soft palate. In these cases, a central piece of tissue, typically containing the palatine muscles, is present between the two fissures (Sager and Nefen, 1998; Griffiths and Sullivan, 2001).

A special type of palatoschisis is the occult, sub-mucous cleft palate in which incompletely fused palatine bones are covered by a continuous mucosa (Okano et al., 2006).

Most commonly, palatoschisis occurs as a solitary entity. However, in approximately 8% of the affected dogs, a cleft palate or cleft lip is associated with developmental anomalies affecting other organ systems (Ingwersen, 2005), most often the skeletal system (Nelson, 2003).

ETIOLOGY AND PATHOMECHANISMS

Genetic causes and breed predisposition

In human medicine, 25-30% of the cases of palatoschisis can be attributed either partially or completely to a certain genetic component (Leite et al., 2002). At least 20 different genes in mice and man are essential for normal palatogenesis (Kang and Svoboda, 2005; Okano et al., 2006). Any disruption of the action of these genes during the critical period of palatal development results in palatoschisis. In such cases, this defect is mostly combined with other structural or functional anomalies as a part of a specific syndrome (Murray and Schutte, 2004).

In dogs, little or no specific data on the genetic background of palatoschisis can be found in the literature (Kemp et al., 2009), but the typical aforementioned breed predispositions strongly suggest a hereditary basis for this anomaly (Elwood and Colquhoun, 1997). Moreover, incidence in the offspring of two affected animals can rise to as high as 41.7% (Nelson, 2003). Although an autosomal recessive inheritance of palatoschisis has been suggested (Richtsmeier et al., 1994), the defect is most likely a complex trait caused by multiple genetic and environmental factors (Murray and Schutte, 2004). Brachycephalic breeds, in particular, are highly susceptible to any additional disruptive factor, as the growth of the palatal shelves towards each other is already compromised by the typical broad head and the greater distance that therefore needs to be bridged by the two palatal shelves (Warzee et al., 2001).

Factors affecting tongue movement

In the early phases of palatogenesis, the tongue is situated between the two palatal shelves. It has to move downwards to allow palatal shelf elevation and

Figure 3. Four neonatal pups from two litters from the same breeder displaying palatoschisis at the level of the secondary palate.
apposition. The retraction of the tongue is mainly accomplished by a hyperextension of the neck. Any disturbance of this mechanism will result in a cleft palate. This failure can be due to hyperflexion of the embryo caused by oligohydramnios (Fraser, 1967), or it can occur as a result of cervical malformations (Ferguson, 1988). Additionally, certain teratogens affecting muscle contractions, such as anabasine, an alkaloid related to nicotine, can prevent retraction of the tongue and consequently cause palatoschisis (Weinzweig et al., 2008).

Factors affecting palatal shelf growth and elevation

The growth and reorientation of the palatal shelves relies mainly on sufficient production and accumulation of mucopolysaccharides (Morris-Wiman and Brinkley, 1993). Certain drugs, such as corticosteroids and non-steroidal anti-inflammatory drugs, interfere with the synthesis of these mucopolysaccharides and with the proliferation of mesenchymal cells, resulting in smaller palatal shelves that fail to fuse (Fraser, 1967; Yoneda and Pratt, 1982; Lu et al., 2008). Particularly in the dog, the administration of acetylsalicylic acid (Aspirin, Bayer) between day 23 and day 30 after conception results in multiple congenital malformations, including palatoschisis in the offspring (Robertson et al., 1979).

The incidence of corticosteroid-induced palatoschisis can be reduced by the administration of pyroxidine (Vit. B₆) or cobalamin (Vit. B₁₂) (Yoneda and Pratt, 1982; Lu et al., 2008). Uncontrolled diabetes mellitus in the dam is also a risk factor for the development of a cleft palate. High levels of plasma glucose interfere with the function of arachidonic acid, which plays a role in palatal shelf elevation (Goldman et al., 1985).

Factors affecting the Medial Edge Epithelium

Apart from their interference with palatal shelf growth and elevation, glucocorticoids also have an effect on the proliferation and/or apoptosis of the Medial Edge Epithelial cells. It has been shown that dexamethasone induces a thickening of the MEE, and that the MEE does not disappear when the two palatal shelves ought to fuse (Lu et al., 2008).

Environmental contaminants such as dioxins, in particular 2,3,7,8-tetrachlorodibenzo-p-dioxine (TCDD), can also disrupt the proliferation and differentiation of the MEE, resulting in a cleft palate (Lu et al., 2008).

Role of folic acid

Folic acid (Vit. B₁₂ or Vit. B₉) is the synthetic and stable form of the naturally occurring folates (Tapiara et al., 2007). Folate supplementation in women in the periconceptional period has been shown to substantially reduce the risk of neural tube defects such as spina bifida, and, although hard evidence is lacking, has also been suggested that it prevents orofacial clefts (Johnson and Little, 2008). In dogs, the incidence of palatoschisis was reduced by 76% after supplementation of folic acid at 5 mg/day in a population of Boston terriers (Elwood and Colquhoun, 1997).

Folates play a major role in DNA synthesis and cell proliferation. Folate deficiencies can lead to megaloblastosis and cell death, particularly in highly proliferative tissues (Antony, 2007). Disturbances of the folate metabolism, for example due to defects of the methylenetetrahydrofolate reductase (MTHFR) or mediated by antiepileptic drugs such as phenytoin, lead to higher levels of circulating homocysteine (Figure 4). Hyperhomocysteinemia can disturb palatogenesis by interfering with the normal methylation of certain important developmental genes (Krapels et al., 2006). It is also responsible for an increase in oxidative stress, resulting in more cell damage and apoptosis (Knott et al., 2003). Finally, the binding of homocysteine to the folate receptors on the placenta can provoke a maternal immune response, resulting in the destruction of the folate receptors and a decrease in folate transport to the fetus (Tapiara et al., 2007).

General teratogens

Apart from causing other major congenital defects, antimitotics and cytostatic drugs can also induce the formation of a cleft palate (Verhaert, 2007). Additionally, vitamin A, and in particular its metabolite retinoic acid, is a well known teratogen that is able to disturb many developmental processes, including palatogenesis. An excess of retinoic acid results in hypoplasia of the palatal shelves with abnormal cartilage and bone formation (Fraser, 1967).

The offspring of dams with aberrant cholesterol metabolism show multiple congenital malformations, including cleft palate. Cholesterol is essential for the proper processing of the Sonic Hedgehog protein, a vital element in many embryonic processes (Krapels, 2004; Murray and Schutte, 2004; Young et al., 2000). Finally, certain viral infections have also been as-
associated with the formation of a cleft palate, mainly as a result of a postclosure reopening at late fetal stages or in the newborn (Fraser, 1967). This situation can correspond with submucous palatal clefts (Dudas et al., 2006).

**DISCUSSION**

The complex developmental pattern of palatogenesis, which spans a relatively long period during organogenesis, relies on the correct action and interaction of many different types of embryonic tissues and processes. For this reason, the formation of the palate is highly susceptible to the disruptive effects of a broad range of genetic and environmental teratogenic factors, which explains the frequent occurrence of palatoschisis both in man and domestic animals (Noden and de Lahunta, 1985). As a further consequence, in individual cases of cleft palate, the identification of the exact etiological agents is nearly always an impossible task (Thornton et al., 1996).

Because many of the disruptive genetic or environmental factors involved in palatoschisis do not specifically act on the process of palatogenesis, but also disturb the development and function of multiple other structures, the presence of a cleft palate might be part of a syndrome (Murray and Schutte, 2004; McGeady et al., 2006). Concomitant congenital defects in other organs should therefore always be taken into account when considering corrective therapy in patients with cleft palate.

On the other hand, as the series of events involved in palatogenesis happens later in embryonic development than most other morphogenetic events do, it is as such possible that teratogenic agents interfere solely with the formation of the palate, without affecting other organ systems (Noden and de Lahunta, 1985). In such non-syndromic cases, corrective therapy, which will be discussed in the sequel paper, might be a favorable option to prolong the life expectancy and assure an adequate quality of life, although breeding with the animal should still be discouraged due to the potential hereditary nature of the anomaly, as it has been shown that cross-breeding with two affected dogs raises the incidence in the descendants to 41.7% (Nelson, 2003). Because of the complex etiology with potential involvement of mechanical or environmental factors, further breeding with the parents of the affected animal is not immediately discouraged, though it has to be carefully considered, evaluating the possibility of a hereditary cause in each specific case.

**REFERENCES**


