EDITORIAL

In its first 21 volumes, *The Cleft Palate Journal* has established a reputation for the publication of multidisciplinary research and clinical information important to the study and treatment of cleft lip and cleft palate, other craniofacial anomalies, and related problems. This issue reflects several changes in the *Journal*—change in Editor, producer, and printer, differentiation between articles and reports, and inclusion of the Craniofacial-Cleft Palate Bibliography. However, in this time of change, the *Journal* staff will strive to maintain the traditions of the *Journal* and the quality of work on which its reputation rests.

This issue was influenced by the previous Editor, Dr. R. Bruce Ross. He and his editorial associates edited drafts of some of the papers published here. He has also assisted, instructed, and supported me during the transition period. Bruce, thank you.

The *Journal* is now being produced by B.C. Decker, Inc. The contribution of the Decker firm to the *Journal* includes a final editing for grammar and conformity to *Journal* style, layout, printing, and distribution. The style for reference list entries has been modified to save space and to conform to current practices. This change is described in the Instructions to Authors. The style of headings and subheadings has also been changed. Thanks to Brian Decker and Agnes McIvor for their contributions.

The distinction between articles and reports is described in a policy statement included in the Instructions for Authors. This statement is intended to reflect the kind of material that the *Journal* has been publishing. It does not establish new direction but rather makes policy explicit for the benefit of contributors and for possible alteration in the future.

The quality of a journal is determined by the quality of the material submitted to it. We thank authors for the contributions we have received, and we encourage future submissions. There is not always agreement among our readers about the value of material accepted for publication. A journal necessarily draws criticism. The Letters to the Editor section provides a channel for constructive criticism and for exchange of informed opinion.

Ralph L. Shelton, Jr., Ph.D.

ABSTRACTS

BARDACH J, MORRIS H, OLIN W, MCDERMOTT-MURRAY J, MOONEY M, BARDACH E. Late results of multidisciplinary management of unilateral cleft lip and palate. Ann Plast Surg 1984; 12:235-248.

The treatment, history, and present status of 45 patients 14 to 22 years of age was studied to examine the efficacy of the multidisciplinary approach to treatment of cleft lip and cleft palate used at the University of Iowa Hospitals and Clinics. The authors found a high incidence of unsatisfactory esthetic and functional results in the treatment of the lip, nose, and palate—approximately 47 percent of patients. A list of possible causes of failure is included in the article. I was disappointed that lay evaluators were not used and that the article contained no evaluation of the overall success or failure of habilitation in these patients. (Lindsay)

Reprints: Dr. J. Bardach
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BROADBENT TR, WOOLF RM. Cleft lip nasal deformity. Ann Plast Surg 1984; 12(3): 216-234.

This article from the Division of Plastic Surgery, Primary Children's Hospital, Salt Lake City, states that the nasal deformity in the patient with cleft lip is produced because the lower lateral cartilage is subluxed inferiorly and laterally. The columella is not truly short. The nasal portion of this cleft deformity is corrected at the time of primary lip surgery by advancing the lower lateral cartilage superiorly and medially, utilizing an intranasal incision which is traced between the lower and upper lateral cartilages and extends well into the nasal tip area. The advanced lower lateral cartilage is fixed to the septum and the upper lateral cartilage in the corrected position. This is an impressive, well illustrated article. (Lindsay)

Reprints: Division Plastic Surgery
Primary Children's Hospital
324 - 10th Avenue
Salt Lake City, Utah 84103

DAN BB. Vietnam and birth defects. JAMA 1984; 252:936-937.

This editorial is an adjunct to an article by Erickson et al (JAMA 1984; 252:903-912) relating to the possibility that Agent Orange causes congenital malformations in the offspring of Vietnam veterans. The technical background to the situation is evaluated, as well as another study relating to the effect of Agent Orange on Australian Vietnam veterans, who demonstrated no evidence that Army service in Vietnam increased the risk of fathering children with congenital anomalies. The Australians' risk was independent of length of service in Vietnam or the elapsed time from the father's return to the conception of a child. The editor emphasized that Erickson et al were appropriately cautious in interpreting the results, but he went on to state that "a fairly strong statement can be made that it is unlikely that serious congenital anomalies in children of men serving in Vietnam resulted from that experience". A plea was made to expend more effort in preventing birth defects in any child. (Gregg)

ERICKSON JD, MULINARE J, MCCLAIN PW, FITCH TG, JAMES LM, MCCLEARN AB, ADAMS MJ. Vietnam veterans' risks for fathering babies with birth defects. JAMA 1984; 252:903-912.

The risk that Vietnam veterans might produce offspring with major structural birth defects was assessed by means of interviews with mothers and fathers of children in both case and control groups and

by reviewing military records. In general, Vietnam veterans had no increased risk of producing children with defects, and veterans who had greater estimated opportunity for exposure to Agent Orange did not appear to have greater risk of producing offspring with all types of defects combined. For some specific defects, among them cleft lip without cleft palate, the estimated risks were higher for subgroups of Vietnam veterans who were more likely to have been exposed to Agent Orange. It was speculated that the higher risk could be due to chance, some experience in the Vietnam service of the father, or some unidentified factor. (Gregg)

HOWELL DM, GUMBINER CH, MARTIN GEO. Congestive heart failure due to giant cutaneous cavernous hemangioma. Clin Pediatr 1984; 23:504-506.

The study presented a female infant with isolated giant cutaneous cavernous hemangioma of the face and secondary severe congestive heart failure. Studies to identify other major arteriovenous malformations were negative. Treatment of the patient with a corticosteroid was not successful in reducing the size of the hemangioma. She required an aggressive anticongestive medical regimen for 2 years. Though not previously described in the literature, high-output congestive heart failure can occur secondary to isolated cutaneous hemangioma. Aggressive medical management may alleviate the need for the increased risk of surgical or other therapeutic approaches in this often self-limited condition. (Glaser)

Reprints: Dr. Carl H. Gumbiner
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Suite 416
Omaha, NE 68114

KASUYA M, HIRAIWA K, NISHI M, KANEDA T, OKA T. Physical measurement and biological age of cleft lip and/or palate patients. J Jap Cleft Palate Assoc 1984; 9:25-34.

The physical growth and development of 115 children with cleft lip and/or palate were studied. The birth physical examination data were collected from the birth records. At their first visits to the authors' clinic, physical statistics were measured and bilateral carpal bone x-ray films were taken. These were compared with the standard Japanese data for corresponding age groups. The results were as follows: the physical statistics at birth were not significantly different, but at the first visit lower height, lighter weight, and smaller chest girth were noted; ossification of carpal bones was greater but not significant in the developmental status; developmental abnormality based on Fanconi's index was most obvious in the bones, and least obvious in body weight; the children with cleft who were between 6 and 12 years of age were small and lean. (Machida)

Reprints: Dr. N. Kasuya
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School of Medicine, Nagoya University
65 Tsurumai, Showa-ku
Nagoya City, Aichi 446, Japan

KERNAHAN DA, DADO DV, BAUER BS. The anatomy of the orbicularis oris muscle in unilateral cleft lip based on a three-dimensional histologic reconstruction. Plast Reconstr Surg 1984; 73:875-881.

The authors from the Children's Memorial Hospital in Chicago were able to examine the mid-face of a full term stillborn infant with a right unilateral cleft lip and cleft palate by means of serial histologic sections and the construction of a three-dimensional model. The arrangement of the orbicularis oris muscle fibres differed markedly from previous descriptions. There was a chaotic arrangement of muscle fibres with no separate muscle layers distinguishable. There was no evidence of muscle bundles paralleling the cleft margins. Muscle fibres on both sides of the cleft inserted into the dermis, although the amount of muscle on the median side was quite sparse compared with the lateral side. The authors feel there is strong justification for further histologic investigation of this anomaly. (Lindsay)

Reprints: Dr. D. Kernahan
Children's Memorial Hospital
Director Plastic Surgery
Chicago, Illinois 60614

KOBUS K. Extended vomer flaps in cleft palate repair: a preliminary report. Plast Reconstr Surg 1984; 73:895-903.

This article is from the Hospital for Plastic Surgery in Polanica and the Medical Center of Postgraduate Education in Warsaw, Poland. It describes another method for closure of the raw surface on the nasal side following transection of the nasal mucosa from the posterior edge of the hard palate. It appears from the illustrations that this mucosal flap was raised from both the posterior pharyngeal wall and the vomer bone. It was rotated posteriorly, turned on itself, and applied to the raw area which resulted when the nasal mucosa was pushed back. The author stated that the flap, unturned, could also be used to augment oral resurfacing if there was a deficit in this area. It is an interesting article for those who are interested in possible surgical refinements. (Lindsay)

Reprints: Dr. K. Kobus
Hospital of Plastic Surgery
PL-57320 Polanica
ZDROJ Poland

KOGO M. Physiological interaction among the levator veli palatini and intrinsic laryngeal muscles: an electromyographic study in the dog. J Osaka Univ Dental Society 1984; 29:158-174.

The study was designed to investigate physiologic relationships among the levator veli palatini and the intrinsic laryngeal muscles in 14 dogs. Reactions to electrical stimulation on the afferent fibers of the pharyngeal branches of the glossopharyngeal nerve were as follows: a single pulse stimulation evoked reflexes with latencies of 10 to 15 msec in the levator veli palatini and cricothyroid muscles, 15 to 20 msec in the thyroarytenoid muscle, and 20 to 25 msec in the lateral cricoarytenoid and interarytenoid muscles, but there was no reflex in the laryngeal abductor. Repetitive pulses of 3 to 5 per sec stimulation induced reflexes in the levator, cricothyroid, and thyroarytenoid muscles and increased the respiratory activities of the lateral cricoarytenoid and interarytenoid muscles. Conditioning stimulus to the laryngeal abductor branch which innervated the posterior cricoarytenoid muscle resulted as follows. It elicited remarkable changes of the levator responses, facilitation within 10 to 20 msec, and inhibition within 30 to 250 msec of the testing interval. The levator reflex was also inhibited by the stimulus to the contralateral laryngeal abductor branch. The inhibitory reaction of the levator by conditioning stimulus was affected by cutting the superior laryngeal nerve and by injection of 1 mg/kg of picrotoxin. (Machida)

Reprints: Dr. M. Kogo
First Dept. Oral & Maxillofacial Surgery
Osaka University Faculty of Dentistry
1-8 Yamada-oka, Suita City
Osaka 565, Japan

LENDRUM J, DHAR BK. The Orticochea dynamic pharyngoplasty. Br J Plast Surg 1984; 37:160-168.

This report is from the Plastic Surgery Unit, Booth Hall Children's Hospital and University Hospital of South Manchester, England. It includes a very clear description of a nonmodified Orticochea dynamic sphincter pharyngoplasty. The results of the use of this technique over a period of eight years in 53 patients are presented. After operation 46 (87%) of the patients had less nasal escape, and 20 patients (38%) had all nasal escape removed. Five patients (9%) had unaltered nasal escape which was considered to be due to flap dehiscence and severe deafness. The authors considered this palatopharyngeal transfer procedure to be the most physiologically attractive of pharyngoplasty procedures. Dehiscence was the main complication the authors encountered and they felt this was due to excessive tightness in the suturing of the flaps. (Lindsay)

Reprints: Mr. J. Lendrum
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Booth Hall Hospital
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Blackley
Manchester M92AA
England

NAKANISHI O, ISHIMARU T, NISHI M. Anesthesia for a cleft lip, jaw, and palate infant with hemophilia A. J Jap Dental Soc Anesthesiol 1984; 12:500-505.

Unilateral cleft lip in a 10-month-old boy with hemophilia A was surgically treated with administration of antihemophilic factor preparation. The authors stressed the importance of evaluating the effect of antihemophilic factor and of maintaining it at sufficient plasma levels. Although no adverse reaction to anesthesia by penthrane and fluothane was found, skillful intubation, extubation, and oropharyngeal suction were necessary. (Machida)

Reprints: Dr. O. Nakanishi
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Kyushu Dental College
2-6-1 Manazuru, Kokura-kita ku,
Kita-Kyushu City 803, Japan

O'DWYER MR, RENNER RP, FERGUSEN FS. Overdenture treatment—one aspect of the team approach for the EEC syndrome patient, J Pedodont 1984; 8:192-205.

This article presented an overview of the team approach for the management of the EEC patient (ectodermal dysplasia, ectrodactyly, and cleft palate). Emphasis was placed on participation by all team members throughout treatment, as well as the appropriate sequence for long-term management. The authors presented the case of a 14-year-old Caucasion female with EEC syndrome. The patient demonstrated the following clinical features: frontal bossing, low nasal bridge, a protuberant lower lip, hypodontia, poorly developed alveolar ridges, decreased vertical dimension, decreased lacrimal duct function, hypopigmentation of skin, sparse facial hair, abnormal nails, missing digits, dry skin, photophobia, and cleft lip and palate. Various phases of the treatment process were described with special emphasis placed on the construction of an overdenture prosthesis to improve dental and facial esthetics and to permit easier social integration and greater peer acceptance. (Ranalli)

Reprints: Dr. R. P. Renner
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PEARL W. Syndrome of anotia, facial paralysis, and congenital heart disease. J Pediatr 1984; 105:441-442.

Anotia (congenital absence of the pinna) is a rare anomaly usually associated with a normal cochlea and vestibular apparatus. In most patients there is bony obstruction of the eustachian tube and fusion of the malleus and incus. The coexistence of anotia with facial paralysis and congenital heart disease is a known sequelae of maternal ingestion of thalidomide during pregnancy; these defects can occur with or without the typical limb malformations. Only a single report of anotia, facial paralysis, and congenital heart disease without exposure to thalidomide has been reported in the literature. The author describes additional patients born more than a decade after the withdrawal of thalidomide, which makes exposure to that drug extremely unlikely. (Glaser)

Reprints: Dr. William Pearl
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POUPARD B, COORNEART H, DEBAERE PA, TREANTON AM. Cleft lip and cleft palate: can the hard palate be left open? A study of sixty-two cases with a followup of six years or more. Ann Chir Plast Esthet 1983; XXVIII:325-336.

Between 1969 and 1982, 193 cases of CLP were treated by the Gillies-Schweckendieck principle. The hard palate was left open as late as possible. The lip and velum were treated in a single operation between 7 and 12 months of age. The hard palate was treated in the patient's teens when speech was normal, or before school age if it was not. The authors found that dental occlusion results were better than ever before—70 percent normal, but that speech results were much worse—only 10 percent of normal. The authors now prefer a very early lip and velum adhesion, between 3 and 6 months of age, and complete closure of the hard palate excepting the al-

veolar area between 2 and 3 years of age. (Lindsay)

Reprints: B. Poupard
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France

RANALLI DN, ELLIOTT MA, RAPP R, MCWILLIAMS BJ, ZULLO TG. Cleft palate training offered by advanced pedodontic programs. Pediatr Dent 1984; 6:104-107.

The purpose of this article was to determine the extent and nature of didactic and clinical training in cleft palate treatment and cleft palate team participation in advanced specialty training programs in pedodontics. A questionnaire was sent to all program directors (N=62) of university- and hospital-based pedodontic specialty training programs in the United States. A 96.8 percent response rate to the questionnaire was obtained. Results of the survey revealed that all advanced training programs in pedodontics include some cleft palate training. However, university programs reported a stronger didactic component, while hospital programs reported greater clinical experience in cleft palate treatment. A majority of advanced pedodontic programs reported participation to varying degrees with a cleft palate team. (Ranalli)

Reprints: Dr. D. N. Ranalli
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School of Dental Medicine
Dept. of Pedodontics, 333-Salk Hall
Pittsburgh, PA 15261

RISKI JE, SERAFIN D, RIEFKOHL R, GEORGIADE GS, GEORGIADE NG. A rationale for modifying the site of insertion of the Orticochea pharyngoplasty. Plast Reconstr Surg 1984; 73:882-894.

A modification of the insertion level of Orticochea is described and the results of this procedure in 55 patients is presented. The basic surgical modification places the flaps higher in the pharynx at the site of attempted velopharyngeal contact as ascertained preoperatively by lateral radiographic techniques. The results are presented objectively, although there has been little use of nasendoscopy. In this procedure 93 percent of patients had significant improvement in oral-nasal resonance balance. (Lindsay)

Reprints: Dr. J. E. Riski
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Speech and Hearing Disorders
Durham, North Carolina 27710

SCHULZ RC. Free periosteal graft repair of maxillary clefts in adolescents. Plast Reconstr Surg 1984; 73:556-565.

The use of free tibial periosteal grafts to the region of the maxillary cleft in adults is described as an alternate simplified method of reconstructing the bony defect. There was some improvement in five objectives. All patients had eventual closure of their oral nasal fistulas, improvement of velar arch morphology, and elevation of the alar base. With the exception of the adult patients, all showed improvement in tooth eruption and evidence of new bone formation. The authors described significant improvement from this relatively simple procedure, but they do not wish to imply routine spectacular cosmetic results. The historical and logical background is well presented. (Lindsay)

Reprints: University of Illinois
Department of Surgery
Division of Plastic Surgery
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ŠMAHEL Z, HORÁK I. Craniofacial changes in unilateral microtia: I. an anthropometric study. J Craniofac Genet & Dev Biol 1984; 4:7-16.

Anthropologic studies were carried out in 100 adult males with microtia. Craniofacial changes were assessed in 45 selected males ranging in age from 20 to 42 years and affected by right-sided microtia of the third degree. The results showed the extent of facial involvement in unilateral severe microtia, as well as the type of the changes. They were expressed quantitatively in terms of metric values. The defect was a typically lateral anomaly with decreased height-depth dimensions of the affected side of the face, while the facial width dimensions and the height dimen-

sions in the median plane were unchanged. The hemihypoplasia was most marked in the distal part of the face and increased towards the otocephalic center. The dimensions of the reconstructed earlobe corresponded on the average to the contralateral lobe, though there were some individual differences and the lobe was inclined anteriorly. Anomalies of the normal earlobe occurred in 27 percent of the individuals examined, and consisted most frequently of lobe protrusion (16%). Associated anomalies of cervical vertebrae were recorded in 13 percent of patients and a familial occurrence of microtia in 4 percent. The body growth was not affected in our patients. (Author's Abstract)

Reprints: Dr. Zbyněk Šmahel
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Division of Congenital Defects
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ŠMAHEL Z. Craniofacial changes in unilateral microtia: II. an x-ray study. J Craniofac Genet & Dev Biol 1984; 4:17-31.

Roentgenocephalometry was used for studies into the extent and character of craniofacial changes in 45 adult males with unilateral (right-sided) microtia. Out of the whole complex of changes associated with this malformation, the mandibular ramus showed the most marked involvement and represented the main cause of the accompanying deviations and asymmetries. On the average, the affected half of the face was compressed toward the level of the external auditory meatus both from above and below, but there was a marked variability in individual patients examined. No signs of asymmetry were disclosed in one-third of the patients while severe asymmetry was present in one-fifth of the patients. Facial hemihypoplasia exerted no substantial influence on the facial profile (when no retrusion of the lower jaw was present), on the sagittal maxillomandibular relations, or on the occlusion of incisors, while in transverse direction a laterosuperior deviation of the mandible towards the affected side was clearly visible. A branchiogenic malformation affected the neighboring structures, the cranial base (a more marked curving), frontonasal segment (septum and premaxillar deviation), and the neurocranium (posterior rotation of the cranial vault). The inner ear structures (semicircular canals) were affected only rarely (in 4% of patients). These findings complemented the results obtained in the first part of our study and confirmed the complex character of this inborn anomaly. (Author's Abstract)

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SUZUKI N. Method of observation of articulatory tongue movement using dynamic velography. Jap J Oral Maxillofac Surg 1984; 30:45-54.

The author developed a dynamic palatography to record the movements of the tongue against the soft palate. The part covering the soft palate consisted of a latex sheet about 40μ thick with gold electrodes 1 mm in diameter and 35μ thick, which were arranged in seven rows side to side and six columns front to back, at 5 mm intervals to each other. The device was attached to the soft palate with sodium polyacrylate and to the teeth via an acrylate resin plate on the hard palate. The electrodes were connected to the recorder, and contact of the tongue could be observed by both the instructor and the patient during speech. The device was applied to eight normals and four operated patients with cleft palate for various speech tasks. Analyses of the palatograms and the stability and accuracy of recording were demonstrated. (Machida)

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TOS M, SANGERUO S, HOLM-JENSEN S, SORENSEN CH. Spontaneous course of secretory otitis and changes of the ear-

eardrum. Ann Otolaryngol 1984; 110:281-298.

Seven repetitive tympanometric screenings were performed on 222 nonselected otherwise healthy children, from ages 4 to 7 years. Otomicroscopy was performed at the last three screenings. Attic retractions of variable degree, atrophy, or tympanosclerosis of the pars tensa were present in 24 percent of the children at age 5 years, 37 percent at age 6 years, and 39 percent at 7 years. The authors believe that longstanding negative middle ear pressures and inflammatory reactions in the eardrum induced by secretory otitis media cause eardrum changes, especially attic retraction and pars tensa atrophy. The identified atropic tympanic membranes had the longest exposure to negative middle ear pressure, and these ears probably had the longest history of secretory otitis. Intubation of severe untreated cases did not reduce the frequency of eardrum changes. Early treatment of secretory otitis by adenoidectomy yielded the best results, and early intubation resulted in more pathologic changes than were found in the severe untreated group, in the authors' experience. Although the eardrum changes were frequent, most had no functional implications and some were reversible. Surgical treatment of secretory otitis should be individualized and when doubt exists, it is permissible to postpone treatment for an interval of observation. Although congenital facial clefting is not the primary thrust of this paper, because otitis media is a frequent complication in craniofacial patients, the information in this article should be of interest to those who treat these anomalies. (Gregg)

Reprints: Dr. M. Tos
Ear, Nose, and Throat Department
Gentofte University Hospital
DK-2900 Hellerup, Denmark

WALBY AP, SCHUKNECHT HF. Concomitant Occurrence of Cochleosaccular Dysplasia and Down's Syndrome. Arch Otolaryngol 1984; 110:477-479.

The case reported and illustrated is a 22-year-old woman with Down's syndrome whose right cochlea and saccule were consistent with the description by Scheibe. The findings included loss of cochlear and saccular hair cells and supporting cells, abnormal stria vascularis containing PAS-positive material that was present also in the saccular macula, collapse of Reissner's membrane and the saccular wall, spherically-deformed tectorial membrane, variable atrophy of the cochlear and vestibular nerves, and normal utricle and semicircular canals. In addition, her temporal bone had a short cochlea and lateral semicircular canal consistent with previous descriptions of Down's syndrome. Her family background showed three individuals with profound deafness and two with Down's syndrome. This individual had no facial clefting, but there was a history of a "semicleft palate" in a maternal cousin. The available literature is reviewed briefly. (Gregg)

Reprints: Dr. H. F. Schuknecht
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WILLIS J, ed. Update on birth defects with isotretinoin. FDA Drug Bulletin 1984; 14:15-16.

Isotretinoin, a vitamin A isomer, used in treatment of severe, recalcitrant cystic acne, has been contraindicated in pregnancy, based upon well-documented animal teratogenicity. As of July 1, 1984, the FDA had received reports of 21 major birth defects and 24 spontaneous abortions in pregnant women who used the drug, usually before the women knew they were pregnant. The defects involved a syndrome of small or absent ears, neurologic injury, and cardiovascular defects, alone or combined. Facial dysmorphia with small mouth and lower jaw, and sometimes with palatal clefting, were also reported. Babies from 24 other completed pregnancies were reported to be normal, but only a few of these could be established as having been exposed to the drug during a critical period (defined as from 28 to 70 days following the onset of the last menstrual period). Five other infants appeared normal at birth but were later found to have brain

injury, blindness, facial palsy, deafness, and ventricular septal defect. Most women who realized they had become pregnant while taking the drug underwent induced abortions. Among 25 women who did not, and were exposed to isotretinoin between the fourth and tenth week of pregnancy, 4 had babies with birth defects, 11 had spontaneous abortions, and 10 had children who were apparently normal. Because of these findings the FDA has prepared a new leaflet for distribution to patients and has advised blood banks not to accept donors who are on isotretinoin therapy or who have taken the drug less than a month prior to donation. The conclusion was reached that women of childbearing age should be fully informed of the drug's teratogenicity and the comparative reliability of various contraceptive methods. (Gregg)

BOOK REVIEWS

Atlas of Speech and Hearing Anatomy.

KAHANE JC, FOLKINS JF. 350 pp. Columbus: Charles E. Merrill, 1984. $18.95

The 22 chapters of this atlas are divided into three parts: The Speech Mechanism, The Auditory System, and The Nervous System. The material is composed largely from anatomical specimens of human dissections and is presented in black and white photographs, photomicrographs, drawings, and illustrations. These figures are clearly numbered and lettered to identify the parts of the structure with a concise description in an accompanying legend. Many of the photographs will be familiar to the readers of the *Journal* since they have appeared in this publication and related specialty journals.

The material is drawn from a variety of sources and represents a blend of classic and contemporary research. In addition to conveying basic anatomical information, the material is intended to acquaint the reader with various techniques used in anatomical research. To this end, examples of gross dissection, microdissection, light microscopy, scanning and electron microscopy, and macrophotography are reviewed.

This book was designed to accompany existing textbooks and to supplement a variety of courses in speech and hearing sciences, communicative disorders, and allied disciplines. It contains chapters devoted to the velopharynx and the craniofacial complex, and atempts to address the functional composite of the many structures that comprise the speech mechanism. I believe the authors have done a creditable job in designing this atlas to accompany textbooks and supplement existing courses in a variety of disciplines. It should prove very useful and informative as a reference in surgical and dental specialties, as well. Its major audience will comprise professionals and students in communication sciences and disorders. It appears to be one of the more comprehensive sources dealing with speech and hearing anatomy, especially in this price range, to appear on the market in over a decade.

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Dental Anatomy: It's Correlation with Dental Health Service (3rd ed)

WOELFEL JB. 390 pp. Philadelphia: Lea & Febiger, 1984. No price provided.

This book attempts to integrate dental anatomy with forensic dentistry, dental pathology, oral and facial anatomy, endodontics, periodontics, restorative dentistry, and the vascular supply associated with the oral cavity. The cranial nerves that supply the mouth and surrounding structures (V, VII, IX, XII) are reviewed; the temporomandibular joint and occlusion are discussed.

While Professor Woelfel attempts to correlate dental anatomy with the overall dental health service (and succeeds to a remarkable degree) this book appears to be intended primarily for dental and dental hygiene students. Readers of the *Journal* who are involved in teaching courses in dental schools might want to review this for possible inclusion in introductory courses.

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CALL FOR ABSTRACTS

An international workshop entitled *Mechanisms That Cause Craniofacial and Oral Birth Defects* will be held at UCLA Center for the Health Sciences, Los Angeles, California on August 1 and 2, 1985. This is a satellite conference of the Tenth International Congress of the International Society of Developmental Biologists.

This conference will focus on genetic and environmental factors that increase or decrease susceptibility to craniofacial and oral anomalies. The primary objective is to integrate experimental data in such a way that molecular and cellular mechanisms causing birth defects may become apparent. The scope of the conference is multidisciplinary including, but not limited to, human and animal investigations, basic scientific and clinical approaches, epidemiology, teratology, pharmacology, embryology, biochemistry, endocrinology, intercellular communication, Mendelian and molecular genetics, cytogenetics and chromosomal analyses, immunologic aspects of pregnancy, and the role of the placenta, all in the context of the regulation of growth and development of craniofacial and oral structures. The international conference will provide a forum to stimulate discussions about reducing the occurrence of these dreaded maladies. Titles and 200–250 word abstracts in English are requested. Abstracts should include statements of the hypothesis, methods, results, and conclusions. Please submit abstracts for consideration as soon as possible, but no later than February 28, 1985.

For information contact Joseph J. Bonner, Ph.D., The Dental Research Institute, UCLA Center for the Health Sciences, Los Angeles, CA 90024. Telephone: (213) 206-8045.

SEVENTH ANNUAL WORKSHOP IN SURGICAL TECHNIQUES IN CLEFT LIP AND PALATE

The workshop is cosponsored by the A. Webb Roberts Center for Continuing Education of Baylor University Medical Center and the Foundation for Craniofacial Deformities in Dallas, Texas.

It will be held at the Snowmass Club, Snowmass, Colorado, March 6–9, 1985. Sessions will run Wednesday through Saturday from 7:30 a.m. to 12 noon. Registration will begin at 7:00 a.m. on March 6.

The workshop emphasizes the correct surgical technique used in cleft lip and palate and correction of the associated nasal deformities. Special emphasis will be placed on the modern surgical procedures used to correct secondary deformities of the lip, palate, nose, and the secondary maxillofacial deformities. Panel discussions will focus on prognostic purposes in the assessment and treatment of difficult deformities including bilateral clefts, nasal deformities, and velopharyngeal incompetency. All problems related to surgical treatment of the cleft lip and palate and the associated maxillofacial deformities will be integrated into the presentation and panel discussion. Various surgical procedures will be demonstrated on videotape. A session in nasoendoscopy will offer an opportunity for hands-on experience in this technique. The workshop participants will present problem case studies on Saturday morning.

Workshop facilitators include: Codirectors, Kenneth E. Salyer, M.D., Dallas, Texas, Janusz Bardach, M.D., Iowa City, Iowa, and Ian Jackson, M.D., Rochester, Minnesota. Peter Randall, M.D., Philadelphia, Pennsylvania, is the special guest.

The workshop entitles participants to CME Credit, Category 1.

The registration fees are $500.00 for surgeons and $300.00 for residents.

For further information contact: A. Webb Roberts Center. Telephone (214) 820-2317

CORRECTION OF MAXILLOFACIAL DEFORMITIES

A symposium on Correction of Maxillofacial Defomities cosponsored by the ACPA and the American Society of Maxillofacial Surgeons, will be held May 10–12, 1985 in Miami, Florida. Presentations will focus on diagnosis, treatment planning, orthodontia, and surgery in relation to maxillofacial deformities and hemifacial microsomia. A hands-on workshop will follow. See registration materials included in this issue for further details.

TREATMENT SEQUENCES FROM BIRTH TO ADOLESCENCE

An ACPA symposium on Treatment Sequences from Birth to Adolescence will be held May 12, 1985 in Miami, Florida. The South Florida Cleft Palate Team and the University of Miami Craniofacial Anomalies Program will present a 25-year multidisciplinary review of successful and unsuccessful techniques. See registration materials included in this issue for further details.

SHERATON BAL-HARBOUR MIAMI, FLORIDA SITE OF THE 1985 ACPA/ACPEF MEETINGS

It is a pleasure to announce that the 42nd Anniversary Meeting of the Association will be held in Miami, Florida on May 12–16, 1985 at the Sheraton Bal-Harbour. The annual meeting will feature sessions of general interest, coordinated specialty sessions, and study session workshops in a schedule which has been arranged to permit enjoyment of Florida sunshine without curtailing program activities. Social events include the traditional annual luncheon, an evening dinner dance at Les Violines, and many tours for registrants and their guests. See registration materials included in this issue for details.

THE FIFTH INTERNATIONAL CONGRESS ON CLEFT PALATE AND RELATED CRANIOFACIAL ANOMALIES

The Fifth International Congress on Cleft Palate and Related Facial Anomalies will be held September 2–7, 1985 in Monte Carlo. For information contact SOCFI (Societé d'Organisation de Congres Français et Internationaux), Fifth International Congress on Cleft Palate, 7, rue Michel Ange, 75016, Paris, France.

SURGICAL, SPEECH, AND ORTHODONTIC MANAGEMENT OF ORAL-FACIAL ANOMALIES

A conference on Surgical, Speech, and Orthodontic Management or Oral-Facial Anomalies will be held in Washington, DC on March 9 and 10, 1985. For information contact Dental Continuing Education, Georgetown University, 3800 Reservoir Road Northwest, Washington, DC 20007. Telephone: (202) 625-7639.

International Craniofacial-Cleft Palate Bibliography

The Craniofacial-Cleft Palate Bibliography has been published quarterly by the American Cleft Palate Association since 1968. Initially, the committee responsible for the Bibliography was a part of the American Cleft Palate Educational Foundation. More recently, it has become a part of the Association itself. References are gathered by the National Library of Medicine which employs the Medical Literature Analysis and Retrieval System (MEDLARS). The Bibliography includes all papers on selected topics that are indexed by Index Medicus, arranged by subject and author. Publications are cited from medicine, dentistry, speech, and basic science that pertain to craniofacial anomalies, including cleft palate.

The Craniofacial-Cleft Palate Bibliography Committee and the officers and council members of the American Cleft Palate Association decided to incorporate the Bibliography into *The Cleft Palate Journal* in order to increase access to the Bibliography to Association members and *Journal* subscribers. This issue of the *Journal* is historic in that it is the first issue to contain the Bibliography. In the future, each issue will include a Bibliography section. Later, annual and 5-year cumulative bibliographies may be prepared for distribution apart from the *Journal.* Back issues of the Bibliography are available from Jane A. Graminski, Executive Director, American Cleft Palate Association, 331 Salk Hall, University of Pittsburgh, Pittsburgh, Pennsylvania 15261.

The Bibliography is intended to assist professionals involved in research and patient care. The list of topics searched can be revised to meet the needs of the readership. Please feel free to communicate directly with me, Mrs. Graminski of the Association office, or Association officers to share information or to make suggestions or criticisms. We hope that with your participation the Bibliography will become an increasingly valuable tool.

Mutaz B. Habal, M.D., F.R.C.S.(C), F.A.C.S.
Associate Editor
Craniofacial-Cleft Palate Bibliography

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