

**To the Readership:**

The Sixth International Congress on Cleft Palate and Related Craniofacial Anomalies was held in Jerusalem this past June 18 through 23. The Editor and Editorial Board wish to congratulate Dr. Menachem R. Wexler (a member of the Journal's Editorial Board) on a very successful Congress, both academically and socially. There were over 400 registrants in attendance from North America, South America, Europe, Asia, and Africa. The planning by Dr. Wexler, his local arrangements committee, and the representatives of Kenes Tours was flawless. Also to be congratulated are all of the Congress delegates who presented over 320 papers, participated on panels and in teaching sessions, and also presented posters, video tapes, and films that covered all areas of multidisciplinary interest. The weather in Jerusalem cooperated fully, and the tours arranged for the Congress delegates were truly spectacular. The delegates were also treated to a stirring sound and light show in the Citadel

of the old city of Jerusalem and to exclusive tours of the new museum in the Citadel, the Jerusalem Museum, and the Dead Sea Scrolls. At the Jerusalem Museum, we were addressed by the flamboyant, outspoken, and well-known mayor of Jerusalem, Teddy Kollek. Our final evening, hosted by Dr. and Mrs. Wexler proved to be a festive occasion highlighted by a spectacular multimedia presentation and several hundred delegates trying their hand (and feet) at Israeli folk dancing. The delegates met on the last day of the Congress and voted to hold the next Congress in Australia. The Australian delegation will choose the location, and we hope to announce the location and the date of the Seventh International Congress on Cleft Palate and Related Craniofacial Anomalies as soon as it is available.

The Editor

## INTERNATIONAL ABSTRACTS

BAFITIS H, STALLINGS JO, BAN J. (1989). A reliable method for monitoring the microvascular patency of free jejunal transfers in reconstructing the pharynx and cervical esophagus. *Plast Reconstr Surg* 83:896-898.

Reconstruction of the pharynx and esophagus with revascularized segments of jejunum remains a time-proven entity. Most thromboses and subsequent flap failures have occurred within the first 24 hours after revascularization of the flap. What would therefore be desirable is a safe, proven monitoring system to assess the patency of the microvascular anastomoses and subsequent viability of the transferred bowel segment. This paper reports on such a monitoring system, which involves the creation of a surgical window on the anterior cervical flap. The jejunal serosa is tacked to this window, and a thin split-thickness skin graft is placed directly on the bowel. The technique is simple, safe, efficacious, and leaves no significant defect. (Authors' abstract)

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COHEN M, FIGUEROA AA, ADUSS H. (1989). The role of gingival mucoperiosteal flaps in the repair of alveolar clefts. *Plast Reconstr Surg* 83:812-819.

Secondary bone grafting of alveolar clefts has become a well established procedure. However, little attention has been given to the soft tissue coverage of these grafts. We present our experience with 32 patients in whom gingival mucoperiosteal flaps were used exclusively in conjunction with bone grafting for patients with residual alveolar clefts. The indications and timing of the procedure as well as the steps of the technique are presented. The advantages of bone grafting at the stage of mixed dentition and the superiority of gingival mucoperiosteal flaps, including teeth eruption through the graft, additional teeth support, dental hygiene and esthetic appearance of the alveolar ridge, are discussed. Our results are compared with those obtained with similar or other techniques. (Authors' abstract)

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COLE RR, MYER CM III, BRATCHER GO. (1989). Congenital absence of the nose: a case report. *Int J Pediatr Otorhinolaryngol* 17:171-177.

Congenital absence of the nose (arhinia, congenital nasal atresia) is a rare anomaly that is infrequently described in the literature. Herein we present a case of congenital absence of the nose recently evaluated and treated at Children's Hospital Medical Center, Cincinnati, OH. Computed tomography and magnetic resonance imaging studies were obtained. To our knowledge, no such radiographic evaluations have been described in patients with congenital absence of the nose. In addition to complete absence of the anterior soft tissues of the nose, thin anterior and thick posterior atretic plates were present. Magnetic resonance imaging was useful in defining the nature of the soft tissue mass that filled the single hypoplastic nasal cavity. The lip, alveolus, and palate were remarkably well developed. A thorough investigation revealed no other congenital defects. At 15 days of life, because of the airway support required and the associated feeding difficulties, a nasal airway was created using a combination of sublabial, transpalatal, and percutaneous approaches. Frequent home dilation of the surgically created opening has been successful in maintaining nasal patency, thus allowing the patient to go without continuous stenting. (Authors' abstract)

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COLTON RH, CASPER JK, BREWER DW, CONTURE EG. (1989). Digital processing of laryngeal images: a preliminary report. *J Voice* 3:132-142.

A low-cost microcomputer (Amiga 1000) and software were used to digitize and analyze slides, high-speed films, and videotapes of laryngeal images. The images were digitized with a 320 horizontal by 200 vertical pixel resolution and at 16 gray levels. Various algorithms were used to analyze the images, including color equalization, color merging, edge detection, and histogram analysis. An example is presented in which the area of a nodule and the area of the glottis are measured using some of the processing techniques and are compared with similar measurements obtained by hand. The quality of the digitized images obtained with this low-cost system is very

good. Simple image-processing techniques, commercially available, are well suited to the analysis of laryngeal images and should permit sophisticated processing of movement of structures within the larynx. (Authors' abstract)

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FARKAS LG, POSNICK JC. (1989). Detailed morphometry of the nose in patients with Treacher Collins syndrome. *Ann Plast Surg* 22:211.

Patients with Treacher Collins syndrome were studied regarding 10 nasal, one orbital, and four facial measurements, as well as 10 facial proportion indexes. Data from 15 to 24 patients were related to normal values. The most normal feature was found to be the nose. The basic measurements of which were optimal. Because harmony between the nose and the face is a basic requirement of esthetic balance in a healthy face, the nose in these patients is the key for calculating changes in the markedly damaged general framework of the face. Abnormal proportion indexes must be corrected by adjusting the abnormal measurement to its optimal level. Thus, the abnormally short bizygomatic width had to be increased by a mean of 13 to 21 mm. Both the nose and the face were usually normal—long thus producing acceptable proportions in these patients. Some size disproportions were found between the root and the soft nose. Their adjustment should be part of the general plan to correct the face of a patient with Treacher Collins syndrome. (Authors' abstract)

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FRANCO JE, VAN SICKELS J, THRASH WJ. 1989. Factors contributing to relapse in rigidly fixed mandibular setbacks. *J Oral Maxillofac Surg* 47:451–456.

The incidence of and factors accounting for relapse in 25 subjects who underwent mandibular setbacks via a bilateral sagittal split osteotomy with rigid fixation were studied. Fourteen had single-jaw operations, and the remaining 11 had concomitant maxillary procedures. Cephalometric radiographs were reviewed preoperatively, immediately postoperatively, and 6 months to 3 years after surgery. Relapse was defined as forward movement of pogonion during the postoperative period. No difference in the movement of the mandible in one- or two-jaw cases was noted. Even with excellent occlusal results, there was a tendency for the mandible (chin point) to rotate forward. In the one-jaw cases, 43.7 percent relapse was noted, whereas a 53.4 percent relapse was seen in the two-jaw cases. A regression analysis showed that the magnitude of setback was the single factor that significantly predicted relapse in one-jaw cases, whereas alteration of the proximal segment accounted for relapse in two-jaw procedures. These results seem interrelated when considering alterations in the spatial arrangement of the muscular tissues and their attachments. (Authors' abstract)

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HURST JA, BERRY AC, TETTENBORN MA. (1989). Unknown syndrome: congenital heart disease, choanal stenosis, short stature, developmental delay, and dysmorphic facial features in a brother and sister. *J Med Genet* 26:407–409.

The authors report a brother and sister born to nonconsanguineous parents. They both had an atrial septal defect and ventricular septal defect. In addition they had short stature, microcephaly, developmental delay, and the same dysmorphic facial appearance of a short nose, epicanthic folds, a long philtrum, and narrow upper lip. The boy had bilateral choanal hypoplasia and stenosis. (Authors' abstract)

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ISHIKAWA Y, KAWANO M, HONJO I, AMITANI R. (1989). The cause of nasal sinusitis in patients with cleft palate. *Arch Otolaryngol Head Neck Surg* 115:442-446.

To determine the reason for the high incidence of nasal sinusitis in patients with cleft palate, the type of cleft, degree of nasal septal deviation, velopharyngeal function, and presence of pharyngeal flap were investigated in relation to nasal sinusitis. We also examined the relationship between the side of sinusitis and the cleft side in patients with unilateral cleft palate. Maxillary sinus development, nasal mucociliary transport, and ciliary beating frequency of ciliated cells were also examined. The saccharin test indicated that nasal mucociliary transport was impaired. This impairment is believed to be one of the reasons for the high incidence of sinusitis in patients with cleft palate. (Authors' abstract)

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LAVELLE CLB. (1989). Statistical methodology applied to facial studies. *J Craniofac Genet Dev Biol* 9:93-105.

The majority of cephalometric studies of anomalous, craniofacial taxonomy and evaluation is based upon either isolated cases or methods that cannot withstand rigorous scientific scrutiny. A number of techniques have been devised to resolve such deficiencies, although the image quality of lateral cephalographs limits the precision of their measurement. Thus, further advances in the statistical evaluation of anomalous craniofacial forms hinge upon the acquisition of more precise images. (Author's abstract)

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LOSKEN HW, MORRIS WMM, UYS, PB, WRIGHT AJ, ROUX PAJ. (1989). Crouzon's disease. Part 1. One-stage correction by combined face and forehead advancement. *S Afr Med J* 75:274-279.

This is an article informing the general practitioners of South Africa about the one-stage correction of facial deformities of Crouzon's disease. The advantages and disadvantages of this major craniofacial procedure are discussed, with a two-case description that shows some very satisfying results. (Fernandes)

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MARSH JL, VANNIER MW. (1989). Three-dimensional surface imaging from CT scans for the study of craniofacial dysmorphology. *J Craniofac Genet Dev Biol* 9:61-75.

Computer-assisted medical imaging technologies provide new tools for the study of congenital craniofacial deformities. Three-dimensional surface reconstructions have been developed to simplify the interpretation and improve the utility of computed tomography scans of the head. While three-dimensional reconstructions initially were applied to assist management of craniofacial deformities, these images now are finding utility in the study of unique anomalies, the definition of group characteristics for dysmorphic heads, the differentiation of similar phenotypes, and the documentation of the effects of cranial surgery on craniofacial growth. These findings should assist the formulation and evaluation of hypotheses regarding mechanisms of congenital malformation and deformation. (Authors' abstract)

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MAY M, D'ANGELO AJ. JR. (1989). The facial nerve and the branchial cleft: surgical challenge. *Laryngoscope* 99:564-565.

The relationship of the facial nerve to a fistulous tract that represents a Type II first branchial cleft cyst is extremely variable and impossible to predict preoperatively. The approach described in this article is designed to permit total excision of the cleft cyst and fistula with minimal risk of injury to the facial nerve. (Authors' abstract)

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MELCON MC, HOIT JD, HIXON TJ. (1989). Age and laryngeal airway resistance during vowel production. *J Speech Hear Disord* 54:282-286.

An investigation was conducted to determine whether laryngeal valving economy, as reflected in measures of laryngeal airway resistance during vowel production, varies across adulthood. Sixty healthy men were studied, 10 from each of six age groups—25, 35, 45, 55, 65, and 75 years ( $\pm 2$  years). Results indicated that there are age-related differences in laryngeal airway resistance during vowel production and that these differences are characterized by a lower mean resistance in 75-year-old men than in younger men of the ages studied. This finding provides insight into the impact of age on laryngeal function and has important implications for the evaluation and management of men with voice disorders. (Authors' abstract)

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MORR KE, WARREN DW, DALSTON RM, SMITH LR, SEATON D, HAIRFIELD WM. (1988). Intraoral speech pressures after experimental loss of velar resistance. *Folia Phoniatr* 40:284-289.

The present study demonstrated that the task of pressure regulation is attained under the circumstances of sudden oronasal coupling resulting from voluntary lowering of the velum. This is not the same as perturbation produced by the insertion of bite blocks or bleed valves or as velopharyngeal inadequacy associated with cleft palate or acquired defects. Nevertheless, the response to the perceived error or change is the same. Intraoral pressure is maintained at an appropriate level. Whether the response to voluntary loss of velar resistance involves increased respiratory effort, resistance adjustments by other speech structures, or both will be the subject of a future investigation. (Authors' abstract)

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PARK HS, ELLIS E III, FONSECA RJ, REYNOLDS ST, MAYO KH. (1989). A retrospective study of advancement genioplasty. *Oral Surg Oral Med Oral Pathol* 67:481-489.

This study examined the immediate and postsurgical changes in the hard and soft tissues of the chin after advancement genioplasty by means of oblique osteotomy of the mandibular symphysis. Twenty-three patients who had undergone this procedure were evaluated cephalometrically for up to 6 months after surgery. The results indicated that the position of the genial segment is stable after advancement. There was a good correlation between the amount of hard versus soft tissue change with surgery in the horizontal direction, but a poor correlation in the vertical plane. There was, however, a great amount of variability from one patient to the next in most of the variables examined. Follow-up results were generally very stable. (Authors' abstract)

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RUNE B, JACOBSSON S. (1989). Dental replacement resorption after bone grafting to the alveolar cleft. *Plast Reconstr Surg* 83:614-621.

In a review of 100 consecutively performed bone grafts to the alveolar cleft, replacement resorption was found in seven teeth adjacent to the cleft. Damage to the periodontal tissues during surgery is considered to be the main cause of this complication; granulation tissue from the bone graft may have some influence. Treatment of the affected teeth eventually includes extraction or surgical removal. To minimize the risk for this complication, the authors suggest that bone grafting should be done when the canine (or lateral incisor) is in an early stage of eruption and that orthodontic uprighting of the medial incisor should be done after surgery. (Authors' abstract)

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SAMANT A. (1989). A one-visit obturator technique for infants with cleft palate. *J Oral Maxillofac Surg* 47:539-540.

Feeding problems are known to occur with newborn infants who have cleft palates. The primary reason is inability to suck effectively. A temporary device is needed that can cover the defect to facilitate suction and prevent regurgitation through the nose. An obturator can be made until surgical intervention is planned. This is inserted in the child's mouth at the initial visit. (Author's abstract)

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SCHENDEL SA, PEARL RM, DE'ARMOND SJ. (1989). Pathophysiology of cleft lip muscle. *Plast Reconstr Surg* 83:777-784.

Although attention has been focused for decades on the correction of cleft lip deformities, our knowledge about the etiology of such deformities has remained presumptive. Sixty-six muscle biopsy specimens from cleft lip infants were obtained at the time of primary closure. Histochemical stains, histographic analysis, and electron microscopy were performed. A non-neurogenic muscle atrophy was seen that varied in severity, with muscle fibers near the cleft being the most atrophic and disorganized. Muscle fibers stained with the modified Gomori trichrome technique also demonstrated "ragged red" fibers typical of a mitochondrial myopathy. Electron microscopy confirmed large accumulations of mitochondria distorting the fibrils. These mitochondria also were increased in size and densely packed with cristae. This study thus demonstrates that the muscles in cleft lip deformities are not normal. Instead, they reflect either myopathy in the facial mesenchymal mitochondrion or at least a delay in maturation. We hypothesize that some of the morphologic deformities associated with cleft lip may cause a failure of mesenchymal reinforcement of the facial processes at a critical time in development. (Authors' abstract)

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SEYFER AE, SIMON CD. (1989). Long-term results following the repair of palatal clefts: a comparison of three different techniques. *Plast Reconstr Surg* 83:785-790.

A series of 109 patients was divided according to type of palatal defect, technique of repair (pushback, von Langenbeck, or pushback with island flap), results of standardized multifactorial speech analyses, and effectiveness of primary and secondary operations. Sixty-five patients (60 percent) showed improved speech after the initial repair, with 49 of these rated as "good." Forty-five percent improved after the von Langenbeck operation, 57 percent improved after the pushback procedure, and 53 percent improved after the pushback/island flap repair. Persistent hypernasal speech was treated with superiorly based pharyngeal flaps in 18 patients with uniform success ( $p \leq 0.001$ ). The worst results (after all three techniques) followed the repair of bilateral complete clefts. This experience has tempered our expectations in dealing with cleft palate patients, especially those having bilateral defects. (Authors' abstract)

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SNYDER EP, SUBTELNY DJ. (1989). Orthodontic treatment of a patient born with a severe right unilateral cleft lip and palate. *Am J Orthod Dentofacial Orthop* 95:273-281.

The patient was born with a severe cleft of the right lip, alveolus, and palate. After surgical correction of these defects at a very young age, the patient began a 6-year period of active orthodontic treatment at the Eastman Dental Center. With the cooperation of the patient and his parents, successful results, both dentally and skeletally, have been achieved. The treatment results have been stable during the 3-year period following the initial placement of retention. The postretention records show a molar relationship within normal limits and some return of the original spacing located in the mandibular anterior segment. The bonded "Maryland bar" is still in place, and the cast single-tooth partial is still being used. At the proper time, a fixed permanent bridge is planned. (Authors' abstract)

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SUBTELNY J, LI W, WHITEHEAD R, SUBTELNY JD. (1989). Cephalometric and cineradiographic study of deviant resonance in hearing-impaired speakers. *J Speech Hear Disord* 54:249-263.

To study the physiologic basis for deviant resonance in hearing-impaired speakers, cephalometric roentgenography and cineradiography were applied to analyze oropharyngeal relationships during vowels produced in isolation and within a sentence context. The films, synchronized with sound recording, were traced and measured for 10 normal hearing and four hearing-impaired women with deviant resonance. Vocal tract conformations and dimensions were defined by measures of the lips, tongue, mandible, velum, hyoid bone, epiglottis, and laryngeal sinus. Means, standard deviations, and analyses of variance were applied to facilitate descriptions and comparisons between the groups. The hearing-impaired speakers had near normal lip openings for /i/ and /u/ but more open positions for /a/. The tongue tended to retract for the front vowel and front for the back vowel /u/. For high vowels, most of the hearing-impaired speakers had an elevated hyoid, an unusually large vertical dimension between hyoid and laryngeal sinus, and a retracted tongue root, which was associated with a marked retraction or deflection of the epiglottis toward the pharyngeal wall. The cine analysis of the normal hearing speakers showed rather well defined and consistent shifts in tongue position for the front vowels produced in the sentence context. The hearing-impaired speakers with deviant resonance showed greater variation among speakers in tongue body position and a significant retrusion of the dorsum of the tongue at a site significantly lower than observed in hearing speakers. The consistent tongue root retraction during static as well as dynamic speech production is interpreted as support for Boone's hypothesized cause of pharyngeal resonance in speech of the hearing impaired. (Authors' abstract)

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TAKATO T, KAMEI M, KATO K, KITANO I. (1989). Cleft palate in the Beckwith-Wiedemann syndrome. *Ann Plast Surg* 22:347-349.

Patients with the Beckwith-Wiedemann syndrome have numerous anomalies which vary somewhat from case to case. The most common presentation is exomphalos, macroglossia, and somatic gigantism. Although cleft palate in association with this syndrome has been rarely reported, we have observed six patients with cleft palate in 10 patients who were diagnosed with the Beckwith-Wiedemann syndrome. The literature is reviewed and discussed. (Authors' abstract)

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THOMSON HG, HART NB. (1989). Reconstruction of cupid's bow: a quadrilateral flap technique. *Ann Plast Surg* 22:195-202.

The cupid's bow is an important feature of the normal upper lip, and every effort should be made to reconstruct it during initial cleft lip surgery or trauma repair. However, a secondary surgical procedure is often necessary to improve the appearance and symmetry in the

cupid's bow area. For this purpose, the authors present a quadrilateral type of interposition flap that can be used in both unilateral and bilateral cupid's bow reconstruction. This procedure is applicable only when adequate vermilion is available. (Authors' abstract)

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VAN DEMARK DR, GNOINSKI W, HOTZ MM, PERKO M, NUSSBAUMER H. (1989). Speech results of the Zurich approach in the treatment of unilateral cleft lip and palate. *Plast Reconstr Surg* 83:605-613.

This is another example on international peer review. The speech results produced at the Zurich University Dental Clinic and Children's Hospital were studied by representatives from the Department of Otolaryngology of the University of Iowa Hospitals. Thirty-seven of the 54 complete unilateral cleft lip-palate patients, 6-16 years of age, were assessed by well controlled verbal methods and observations of nasal grimacing. Nasendoscopy and videofluoroscopy were not used. The reported speech results are exceptionally high, with 94.5 percent of the patients exhibiting adequate to marginal velopharyngeal competence (40.5 percent competent, 54.1 percent marginal). (Lindsay)

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WARD RE. (1989). Facial morphology as determined by anthropometry: keeping it simple. *J Craniofac Genet Dev Biol* 9:45-60.

Anthropometry remains an efficient, noninvasive method for describing craniofacial morphology in spite of the appearance of more sophisticated technologies. The major advantage afforded by anthropometry is its technical simplicity, a fact that makes it a readily available tool for evaluating patients, planning facial surgery, or delineating basic features of craniofacial syndromes. Anthropometry lacks the detail of more powerful technologies, but it is better suited for populational studies because of the availability of comparative, normal databases. The standard z-scores produced by such comparisons lend themselves to multivariate analysis. This type of comparative analysis is not yet possible for computerized tomography, three-dimensional imaging, or photogrammetry. To illustrate the utility of this technique, an example is cited from an ongoing study of hypohidrotic ectodermal dysplasia (HED) in which anthropometry reveals details of facial morphology overlooked in previous studies. These include the presence of reduced facial height and a striking reduction in the size of the facial features in spite of the fact that facial widths are comparatively normal. Gene carriers show a similar, although nonidentical, pattern of defects. Like all morphometric approaches, anthropometry has its limitations. Well designed protocols minimize these limitations by incorporating multiple facial dimensions in the analysis and by emphasizing careful collection of data with standard instruments and methodology. (Author's abstract)

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ZUKER RM, MANKTELOW RT. (1989). A smile for the Möbius' syndrome patient. *Ann Plast Surg* 22:188-194.

A major problem for the patient with Möbius' syndrome is the inability to smile. With the development of vascularized muscle transplantation, the possibilities for improved facial animation were explored. Muscle transplantation was carried out in seven patients; innervation was provided by the hypoglossal nerve, by the motor nerve to the masseter muscle, or in one patient, by a transfacial nerve graft. In this article the technical aspects of the procedure as well as the results are described in detail. (Authors' abstract)

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## ANNOUNCEMENTS

### ***The Cleft Palate Journal* Announcement Policy**

*The Cleft Palate Journal* is pleased to publish announcements of meetings and educational programs sponsored by professional societies, universities, and hospitals. The meeting must pertain to cleft palate or to other craniofacial anomalies. The information should be limited to the title of conference, sponsoring group, location, date, a brief description of the meeting, and the name and address of a person to contact for further information. Send announcements to Nancy C. Smythe, Executive Director, American Cleft Palate-Craniofacial Association, 1218 Grandview Avenue, Pittsburgh, PA 15211 at least 120 days prior to publication.

## **FUTURE ACPA MEETINGS**

**1990**—St. Louis, Missouri, May 13–18

**1991**—Hilton Head, South Carolina, March 15–22

**1992**—Portland, Oregon, May 11–16

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## **1990 ANNUAL MEETING OF THE AMERICAN CLEFT PALATE–CRANIOFACIAL ASSOCIATION**

The 47th Annual Meeting of the American Cleft Palate–Craniofacial Association will be held Tuesday, May 15 through Friday, May 18, 1990 at the Adams Mark Hotel in St. Louis, Missouri. A symposium on “The Facial Skeleton in Clefts” will be held Sunday, May 13 and Monday morning, May 14 prior to the meeting. The 1990 program will follow a traditional format, beginning with a Welcoming Reception the evening of Monday, May 14. General sessions, concurrent specialty sessions, study sessions, a videotape forum, poster sessions, and a special session for junior investigators will run through Friday noon. Suggestions and comments about the general conduct of the meeting are welcome and should be directed to the 1990 Program Committee chairperson, Mary Anne Witzel, Ph.D., The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, Canada M5G 1X8; telephone (416) 598-6100. Registration information will be sent to all members of ACPA and to subscribers of the *Cleft Palate Journal* in early February 1990.

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## **CORRECTION OF MAXILLOFACIAL DEFORMITIES**

The American Cleft Palate-Craniofacial Association and the American Society of Maxillofacial Surgeons will sponsor a symposium and workshop on Correction of Maxillofacial Deformities April 26–28, 1990 at the Grand Hyatt Hotel in New York, New York. Presentations will focus on diagnosis, treatment planning, orthodontia, and surgery in relation to maxillofacial deformities. A half-day program will focus on Hemifacial Microsomia. A hands-on workshop with power equipment will emphasize practical applications. Registration information will be available through the ACPA National Office in early January.

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## **CLEFT PALATE FOUNDATION RESEARCH GRANT**

The Cleft Palate Foundation (CPF) has established the CPF Research Support Grant sponsored by the Peer Foundation, Florham Park, NJ. This grant is coordinated by the CPF Committee on Research Grants. The purpose of the grant is “to (a) aid in the development of scientific investigators who are committed to problems related to cleft lip and palate and other craniofacial abnormalities and (b) encourage research and projects of significance to cleft lip and palate and other craniofacial abnormalities.” The grant covers a 1-year period and will be awarded annually, with a maximum allocation of \$5,000 per year. Funds are to be used for direct project support (i.e., technical assistance and supplies). Requests for additional awards by the same individual will be judged each year on the basis of a new application. Each applicant must arrange for acceptance at an institution engaged in health care and/or research. Each investigator is directly responsible to the institution for proper management of funds and project performance. Applicants must have attained a professional and/or scientific degree and completed an accredited training program related to the disciplines recognized by the American Cleft Palate–Craniofacial Association (ACPA). Priorities for the grant will be given to young investigators (candidates who have less than 5 years experience since finishing their specialty professional training or Ph.D., etc.) who must be members of the ACPA. Grant applications will be evaluated in nationwide competition and final selection of the grant recipient will be made by the CPF Committee on Research Grants.

All applications will be judged based on the quality of the proposed project, including its relevance, significance, originality, scientific basis, feasibility and the support of a local institution, applicant's previous professional record; his or her demonstrated commitment and promise as a researcher, teacher, or clinician; and the level of commitment to the proposed project. Deadline for receipt of completed applications is December 1, 1989. Proposals will be reviewed at the annual ACPA meeting the following Spring for payment to begin July 1. The final selection will be made by the CPF Committee on Research Grants. Information and applications should be requested from the American Cleft Palate-Craniofacial Association, 1218 Grandview Avenue, Pittsburgh, PA 15211.

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## **THE SAUL KAMEN SEMINAR IN THE MANAGEMENT AND TREATMENT OF THE DEVELOPMENTALLY DISABLED PATIENT**

The Department of Dentistry, Long Island Jewish Medical Center will sponsor this program, taught by an interdisciplinary faculty, on November 12, 13, and 14, 1989. This three-day seminar will emphasize the clinical management of patients with a wide range of physical and mental disabilities. The curriculum is designed to meet the needs of general practitioners, specialists, academicians, institutional dentists and dental hygienists. Tuition is \$395 (\$225 for residents, dental auxiliaries, and students). For further information contact: Ann J. Boehme, Assoc. Director for Continuing Education, Long Island Jewish Medical Center, New Hyde Park, NY 11042, (718) 470-8650.

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## **EARLY VERSUS LATE PALATAL CLOSURE**

An international cleft palate symposium on "Early Versus Late Palatal Closure" will be held in Winnipeg, Manitoba, Canada on March 16 and 17, 1990. For further information contact: Patrick T. Alexander, Ph.D., Director, Department of Communication Disorders, Health Sciences Centre, FE207, 685 William Avenue, Winnipeg, Manitoba R3E 0Z2, Canada, (204) 787-4212.

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## **INTERNATIONAL SYMPOSIUM ON THE INTERDISCIPLINARY MANAGEMENT OF COMPLEX CRANIOFACIAL DISORDERS**

Montefiore Medical Center and the Albert Einstein College of Medicine announce a symposium with an eminent international faculty from multiple disciplines, including plastic surgery, neurosurgery, developmental biology, oral surgery, orthodontics, speech pathology, otolaryngology, pediatrics, clinical genetics, dysmorphology, and other specialties. The visiting faculty includes Derek Bruce, Maurice Choux, M. Michael Cohen Jr., Edward Ellis, Fred Epstein, C. DiRocco, John Jane, Daniel Marchac, Joseph McCarthy, Melvin Moss, Ian Munro, Kenneth Salyer, Luis Schut, Kathy Sulik, Timothy Turvey, Karin Vargervik, Linton Whitaker, and Mary Anne Witzel. The host faculty includes Michael Lewin, Craig Hall, James Goodrich, Ravelo Argamaso, George Cisneros, Sidney Eisig, Robert Marion, Rosalie Goldberg, Karen Golding-Kushner, and Robert Shprintzen. The symposium will be held in New York City from March 28 to March 31, 1990. For further information, contact Dr. Craig Hall, Dr. James Goodrich, or Dr. Robert Shprintzen, Center for Craniofacial Disorders, Montefiore Medical Center, 111 East 210 Street, Bronx, NY 10467, or call (212) 920-4781.

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## **BONE GRAFTING IN CLEFT DEFORMITY**

The International Association of Maxillofacial Surgeons in Training will hold its second symposium in Luxembourg on June 16, 1990. Confirmed speakers include M. El Deeb, S. Hillerup, U. Joos, R. Kole, G. Semb, and B. Wittsenberg. Abstracts are welcome and will be reviewed by the scientific committee on November 30, 1989. For further information please contact: Dr. M. Mommaerts or Dr. C. Politis, IAMFST, c/o Afd. Mond-Kaak-en Aangezichtsheelkunde, St. Jansziekenhuis, Schiepse Box 2, B-3600 GENK, Belgium.

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## **THIRD INTERNATIONAL SYMPOSIUM ON DENTOFACIAL DEVELOPMENT**

This symposium will be held at The Royal Dental College in Aarhus, Denmark, June 23-24, 1990. This interdisciplinary symposium will focus on: excessive vertical dentofacial development and its treatment, respiratory problems and dentofacial development, and TMJ disorders and dentofacial development. For further information contact: Third International Symposium on Dentofacial Development, Department of Orthodontics, Attn: Dr. A.E. Athanasiou, DK-8000, Aarhus C, Denmark.

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